



Department of
Public Safety

GOVERNOR'S WORKING GROUP
on Reviewing the Medical Board's
Handling of the Investigation
Involving Richard Strauss

August 30, 2019



Mike DeWine, Governor
Jon Husted, Lt. Governor

Department of Public Safety

Thomas J. Stickrath, Director

August 30, 2019

Dear Governor Mike DeWine:

Enclosed is the Report of the Working Group on Reviewing of the Medical Board's Handling of the Investigation Involving Richard Strauss, which you requested through Executive Order 2019-16D.

I would like to thank all of the offices and officials identified in your Executive Order for their support to the Working Group, and especially thank the individuals who served on the Working Group. I believe I speak for all of us when I say that it was a privilege to be asked to undertake this serious and necessary review of the Medical Board's handling of the investigation involving Richard Strauss.

Further, the Working Group is prepared to continue its work as outlined in Executive Order 2019-16D, and to undertake any other review that you may require.

Sincerely,

A handwritten signature in black ink, appearing to read "T. Stickrath". The signature is fluid and cursive, with a large initial "T" and a long, sweeping underline.

Director Thomas Stickrath
Ohio Department of Public Safety

REPORT TO THE GOVERNOR

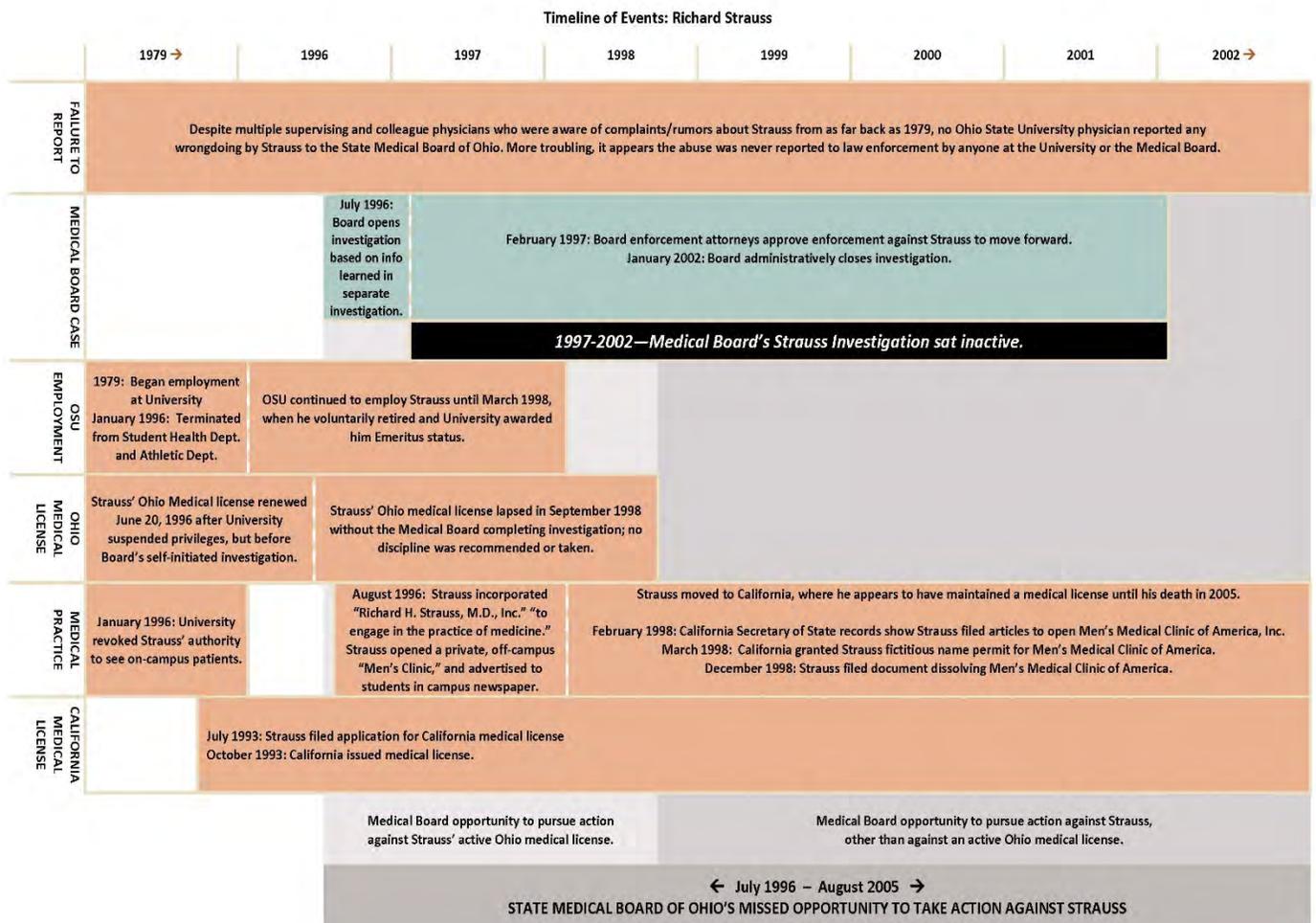
Documented systemic failures at both The Ohio State University and State Medical Board of Ohio prevented any tangible administrative or criminal consequences from ever being taken against Richard Harry Strauss during his lifetime. Strauss' repeated sexual abuse of his patients went effectively unaddressed for nearly the length of his tenure at Ohio State. Although many were aware of complaints or rumors about the abuse, no one advanced concerns raised by students or unraveled Strauss' "medical" defenses of his abuse. Medical Board staff opened case 96-1534A into Strauss in July 1996, initiated, in fact, by one of its own investigators based on information learned from non-physicians at Ohio State that came to light in case number 96-0999, which was prompted by a complaint by Strauss, himself. In December 1996, the Medical Board investigator turned in his report of case 96-1534A to the Board Members overseeing investigations. They referred the matter to the Board's enforcement section, and by February 1997, the Medical Board enforcement attorney had received approval of a plan to gather patient records in order to move forward against Strauss' license. For reasons that simply cannot be determined from the files still available or known or recalled by anyone interviewed by this Working Group, the investigation fell into what one former employee called a "black hole." The Medical Board's investigation sat open but inactive from early 1997 until after Strauss left the University, left the State of Ohio, and allowed his Ohio medical license to lapse in September 1998. The Medical Board's investigation sat inactive while Strauss moved to California where he held a medical license. The Board's investigation, while open, continued without action until it was administratively closed in January 2002, with no official action ever pursued or taken against Strauss.

On May 20, 2019, Governor Mike DeWine issued Executive Order 2019-16D,¹ creating the Governor's Working Group on Reviewing of the Medical Board's Handling of the Investigation Involving Richard Strauss. The Working Group understands that it brings a 2019 perspective to events in and around 1996. It recognized from the outset that identifying deficiencies in that era may appear to some to be hampered by this modern perspective. To be sure, attitudes and understanding around sexual abuse, particularly sexual abuse of males by males, reporting potential sexual impropriety, recognizing predatory behavior by those abusing their positions of authority and power, and conducting survivor-centered and trauma-informed investigations of such cases, have, thankfully, evolved dramatically since 1996. The investigation and prosecution, even the definition, of criminal sexual assault and abuse has broadened significantly in more recent years. The Medical Board has a chapter of rules in the Ohio Administrative Code dedicated to addressing physician sexual impropriety that did not exist in 1996. Growth in its rules and the tools available to handle physician sexual impropriety prompted the current President of the Medical Board and its Executive Director to assure the Working Group that if the Board received information about a physician today like it gathered about Strauss in 1996, the investigation would not sit inactive for years without enforcement. Members of today's Medical Board have communicated that it is much better prepared to work with law enforcement, to seek prompt action against the medical license of perpetrating physicians in sexual impropriety cases, as well as to pursue the licenses of those physician-

¹ Executive Order 2019-16D is attached as Appendix 1 to this Report and available, together with Governor DeWine's other Executive Orders, at: <https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/>.

licensees who fail to report that impropriety to the Board. Still, knowing that it is using today’s lens does not diminish the Working Group’s objective assessment of the 1996 investigation. Rather, it allows a light to shine on that era to describe it straightforwardly and factually. As a result, the Working Group has the opportunity to identify shortcomings from that time to compare the reforms the Medical Board has made since, to identify areas for continued improvement, and to assess whether, under current practices, statutes, and administrative rules, the outcome of the investigation may have had a different result.

As depicted below, the Medical Board and its staff had the opportunity to take meaningful and timely action, whether that was moving against Strauss’ license or participating in a broader intervention to impact Strauss’ ability to see patients.² The Medical Board’s missed opportunity should be viewed not only along with the failures at the University, but in the context of Strauss’ University employment, Ohio medical licensure and disciplinary investigation regarding it, and Strauss’ overall ability to see patients both in Ohio and later, in California. Further, the collapse of those systems was against the backdrop of an astounding failure of anyone in a position of authority to come forward to initiate a Medical Board or criminal investigation into Strauss’ conduct.



² The event comparison timeline depicted here and a timeline of the Medical Board’s investigation into Strauss are attached as Appendices 5 and 6.

For decades, physicians and others alike had the opportunity to report Strauss to the Medical Board and to law enforcement. As the University’s report details, and the Medical Board’s investigation further reflects, rumors, complaints, and credible accounts of Strauss’ abuse of patients were well known and circulated for years. By the time the Medical Board initiated its investigation of Strauss, he was no longer seeing patients at the University, and early in the Board’s investigation, OSU Student Health decided not to renew Strauss’ contract, though he did remain employed by the University. Still, none of the physicians working with Strauss found occasion to report him to the Medical Board or to law enforcement – even after the University suspended him from seeing patients through Student Health. Nor did the University or any of its administrators involve campus or outside law enforcement, even after recognizing that the severity and pervasiveness of Strauss’ abuse compelled the withdrawal of authority to see patients and the nonrenewal of his contract.³ While only physicians had a duty to report Strauss to the Medical Board, lest they risk their own licenses for failing to do so,⁴ anyone encountering his victims or abuse could have alerted the Medical Board. Each had an opportunity, if not an obligation, to report him to law enforcement.⁵

In 1996, when information finally reached the Medical Board, it had its most significant opportunity to stop Strauss from ever again practicing medicine or seeing a patient in or outside Ohio. The Board’s investigation into Strauss included complaints of students from December 1994 through January 1996. The investigation report concluded: “[T]he information provided shows that Dr. Strauss has been performing inappropriate genital exams on male students for years. This has been brought to the attention of officials at the university and just recently action was taken.” Not only had the Medical Board investigator found credible evidence of a violation of the rules and statutes for licensed physicians, but the investigation also included interviews with Strauss’ colleagues who freely acknowledged longstanding, serious concerns about Strauss. More than three years after his license expired, the Board closed its investigation without action. Nothing from the individuals interviewed or from the investigation records indicates that the Medical Board staff involved law enforcement.

³ Since 1996, higher education institutions in the state have also made significant investments in sexual misconduct investigation, education, reporting and resources, usually as a part of an institution’s Title IX commitments. The heightened focus on campus occurred after a series of ‘Dear Colleague’ letters issued by The U.S. Department of Education beginning in 1997, addressing a school’s obligations under Title IX. Schools were further obligated under new provisions in the 2014 reauthorization of the VAWA (Violence Against Women Act) and Campus SaVE Act.

⁴ The physician duty to report in Ohio Revised Code § 4731.224 has been in substantially the same form since its inception in 1987, and requires in part that when any licensed physician “or any professional association or society of such individuals *believes* that a violation of any provision of this chapter . . . or any rule of the board has occurred, the individual, association, or society *shall* report to the board the information upon which the belief is based.” (Emphasis added.) Reportable violations would have included violations of minimum practice standards, ethical rules of the American Medical Association, misdemeanors committed in the course of practice, and misdemeanors of moral turpitude.

⁵ Ohio Revised Code § 2921.22(A)(1) currently and historically provides, with some exceptions, that “no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.” The Working Group recognizes that most will have difficulty discerning what sexual impropriety might rise to the level of a felony, for example, and therefore may not perceive a duty to report. The Working Group also respectfully submits that when in doubt, a referral to law enforcement to assess and potentially investigate the conduct is the preferred, indeed perhaps at times the only, way to determine whether a felony has been committed.

Key Observations from Medical Board Investigation No. 96-1534A into
Allegations of Sexual Impropriety in the Course of Practice by Richard Strauss

- The records indicate that a Medical Board investigator initiated the investigation into Strauss. In July 1996, while investigating another complaint, the Medical Board investigator interviewed University employees and learned that the University had suspended Strauss' authority to see patients through Student Health in January 1996. The investigator, to her credit, recognized the potential severity and reach of Strauss' improper conduct, and wrote a memo to her supervisor recommending an investigation against Strauss be opened. Because no practicing physician came forward to report Strauss, without the investigator's actions (and, in fact, without case number 96-0999 that occasioned mention of Strauss' authority to see patients at Student Health), the Medical Board staff may never have learned of Strauss' abuse.
- The Medical Board had at least nineteen months to move toward revoking Strauss' license, but did not. The Medical Board investigator finished the factual investigation into Strauss in December 1996, and by February 7, 1997, records show that the enforcement attorney completed her new assignment case review with a plan to continue the investigation and subpoena records, noting that Strauss had opened an off-campus men's clinic and was advertising to Ohio State University students in the University student newspaper. On September 30, 1998, more than nineteen months after that plan was approved by the chief enforcement attorney, Strauss' medical license, which had remained active during the Board's investigation, lapsed. In January 2002, almost 5½ years after opening the investigation into Strauss, the Medical Board staff administratively closed the matter with approval from the Board's Secretary and Supervising Member without action. The records do not indicate a rationale for closure. Nor could the Board staff locate a closing letter, despite taking the added step of searching an additional thirty-one boxes that contained complaints also closed on January 25, 2002, to determine if it had been misfiled.
- In 1996, as now, by statute, all investigations conducted by Medical Board staff were overseen by two Board Members, the Secretary and Supervising Member. By practice, unless they authorize a complaint to continue to a formal action/hearing, the full Board is unaware of allegations of sexual impropriety or investigations into them. Anita M. Steinbergh, D.O., a Board Member from 1993 to 2018, appeared before the Working Group. In 1996, she was not in the position of Secretary or Supervising Member. Because of the gatekeeper function of those two Members, Dr. Steinbergh revealed that despite twenty-five years of active service on the Medical Board, the first she learned of the Medical Board's closed 1996 investigation into Strauss was through recent news reports, some twenty years later.
- Despite the self-initiated complaint into Strauss, and the fact that Medical Board investigators specifically identified physicians in 1996 who may have failed to report Strauss, the Board did not pursue action against those individual physicians. The investigator who prompted the Strauss investigation, opened as case number 96-1534A, was under the impression that these doctors' failure to report would be reviewed in a companion investigation against the institution, numbered 96-1534B. Instead, that companion investigation was closed with no further action in January 1997, documented as "opened in error."

- Neither the Medical Board’s record of investigation number 96-1534A, nor those of the University police department (according to University attorneys), reveal a referral of Strauss’ conduct to law enforcement. The lead investigator in case number 96-1534A stated that, at that time, he would have needed the approval of the Secretary and Supervising Member of the Medical Board in order to refer any matter to law enforcement or to conduct a joint investigation with law enforcement. Both the Secretary and Supervising Member who oversaw this investigation are deceased, and the investigator related that he does not recall involving law enforcement to investigate Strauss or requesting to do so. As a result, the Working Group could not determine what, in 1996, the decision-making process was for involving, or in this case not involving, law enforcement.

Going forward, the Medical Board should actively demonstrate that its advances since 1996 ensure that it will never again allow an investigation like Strauss’ to sit inactive, without enforcement. The Board should reassure its constituents, despite the recent and ongoing revelations surrounding Strauss, that it seeks to strike a balance between investigation confidentiality and government transparency, in order to achieve internal accountability and to demonstrate its commitment to eradicating sexual impropriety by its licensees. Medical Board Members and its Executive Director shared that investigations and enforcement actions are tracked, and staff reports on the status of these matters monthly so that if a matter begins to stall, as the Strauss investigation did, the staff can identify it and inquire as to the reason. In addition, Board Members and Board staff have indicated that sexual impropriety cases are triaged for priority handling. The Board is in the process of developing a protocol specific to sexual impropriety cases, is implementing for 2019 a staff audit panel to track handling of sexual misconduct cases, and is exploring how to incorporate victim advocates in its investigative process for sexual abuse cases.

To its credit, the Medical Board held a special meeting on May 23, 2019, within days of the Governor forming this Working Group, to waive the Board’s confidentiality relating to the Strauss investigation.⁶ Since that decision, the Medical Board staff redacted under Ohio public records law copies

⁶ Minutes from the May 23, 2019 special meeting are attached as Appendix 9, and available at the Medical Board website at: <https://med.ohio.gov/The-Board/Board-Meetings-Minutes>. The investigative confidentiality provision states:

(5) A report required to be submitted to the board under this chapter, a complaint, or information received by the board pursuant to an investigation or pursuant to an inspection under division (E) of section 4731.054 of the Revised Code is confidential and not subject to discovery in any civil action.

The board shall conduct all investigations or inspections and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that consent or a waiver of that nature is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The board may share any information it receives pursuant to an investigation or inspection, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information

of investigation 96-1534A into Strauss,⁷ the related investigation 96-1534B into the University,⁸ as well as 96-0999⁹ which started with a complaint by Strauss but led the investigator to the information that ultimately prompted the Medical Board to open 96-1534A. Past and current employees and Board Members expressed the importance of the confidentiality of investigations. Confidentiality of patient information in investigations is paramount. Confidentiality can promote frank and robust discussion of potential mistakes or wrongdoing, while encouraging patients, licensees, and whistleblowers, to report wrongdoing, even when they are unsure whether there is a violation, with no concerns of retaliation. One investigator interviewed pointed out the importance of confidentiality from an investigative standpoint. He indicated that false allegations – including false allegations of sexual impropriety – could lead to malpractice lawsuits being brought against physicians simply because of the existence of an allegation or investigation. Although these are understandable goals and concerns of the Medical Board, the Board must find the appropriate balance between confidentiality on the one hand, and the completeness and transparency of its investigations on the other.

First, the systemic failings in the Strauss investigation were largely procedural, and the procedures should not be confidential. Failing to take action after the investigation was complete and failing to involve law enforcement were procedural lapses. The goals of investigative confidentiality were not served in 1996 by extending confidentiality to procedural and progress/status aspects of the case. In fact, the Medical Board’s goals and duties would be advanced through increased transparency in the status and progress of Board investigations. Periodic reporting of cases to the full Board and/or the public, including the reason for inaction, which does not identify the people involved, does not implicate the investigative confidentiality restrictions and would serve the public interest.

Second, absolute confidentiality of investigative files, in perpetuity, does not serve the public interest. If the Board takes formal action against a licensee, the information supporting that action becomes public. When the Board fails or chooses not to act, however, no public formal action is created, and the investigation upon which that decision was based remains confidential. A survey of the investigative confidentiality provisions of other healthcare boards in Ohio, as well as for state medical boards from several states with high populations and numbers of physician-licensees, showed that investigative confidentiality is the norm, including a prohibition against admissibility in a civil court case. The ways to overcome that confidentiality, though, are anything but consistent. For example, Ohio’s State Board of Emergency Medical, Fire, and Transportation Services, makes its investigations public record “[u]pon completion of the investigation and any resulting adjudication proceedings.” Ohio Rev. Code § 4765.102. In another example, Ohio’s State Chiropractic Board maintains confidentiality, “except that

may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

Ohio Rev. Code § 4731.22(F)(5).

⁷ Redacted copy attached as Appendix 2.

⁸ Redacted copy attached as Appendix 3.

⁹ Redacted copy attached as Appendix 4.

for good cause, the board or its executive director may disclose or authorize disclosure of information gathered pursuant to an investigation.” Ohio Rev. Code § 4734.45(B). Other states allow for the sharing of information upon issuance of a subpoena. Even disclosing investigative information to law enforcement may require a subpoena or the existence of an ongoing criminal investigation. Michigan public records law in combination with its medical board confidentiality does not prohibit the disclosure of “[t]he fact that an allegation has been received and an investigation is being conducted,” “the date the allegation was received,” “the fact that the department did not issue a complaint for the allegation,” and “the fact that the allegation was dismissed.” Mich. Comp. Laws §§ 333.16238, 15.243. New York maintains investigative confidentiality but permits its Commissioner of Health to “disclose the information when in his or her professional judgment, disclosure of such information would avert or minimize a public health threat.” NY CLS Pub Health § 230(10)(a)(v). In Florida, if the panel finds probable cause to proceed against a licensee, ten days after that finding the “complaint and all information obtained pursuant to the investigation by the department” are no longer confidential. Fla. Stat. § 456.073(10). The Medical Board and public interest will be served by some measure of limitation on the current, perpetual confidentiality of Medical Board investigations from which no formal action is taken, like the Strauss investigation.

Moreover, the Medical Board must find ways to work effectively with law enforcement and prosecutors as early as possible in the investigative process of cases involving criminal conduct, including sexual impropriety cases. In doing so, the Board should either develop or avail itself of existing victim advocacy resources. Investigators interviewed by the Working Group said that, historically, many investigators have a law enforcement background, and that there is an investigative willingness to cooperate with law enforcement. While the Board has current plans to develop some victim advocacy resources, this has not been an historical part of its process. Further, the Board has not historically actively sought to include victim advocates in law enforcement agencies or Sexual Assault Response Teams (SARTs), if available. In the experience of the Working Group’s law enforcement members, the early involvement of law enforcement allows for the sharing of information and resources, even if no criminal investigation or charges materialize. Board staff appearing before the Working Group acknowledged that a criminal conviction can directly support the Medical Board taking action against a physician’s license. The Medical Board needs to work with law enforcement within the confines of its confidentiality statute (or seek to change it) while being mindful of the constitutional and other protections afforded a criminal defendant, all with an eye toward effective administrative prosecution of licensing actions in accordance with Ohio administrative law. These and other concerns, however, must be overcome, and not proffered or accepted as insurmountable impediments to cooperation.

FORMATION OF THE WORKING GROUP

On May 15, 2019, after more than a year of work, the outside investigative team for Ohio State University released a report detailing the decades-long trail of sexual abuse of patients perpetrated by OSU’s former employee and faculty member, Richard Strauss. The investigative team found “that Strauss sexually abused at least 177 male student-patients he was charged with treating as a University

physician.”¹⁰ Back in 1996, the State Medical Board of Ohio opened investigation number 96-1534A against Strauss, relating to specific allegations of sexual impropriety involving three patients. Because of the confidentiality required for Medical Board investigations, the OSU report redacted much of the information related to the Medical Board, itself. This Working Group obtained an unredacted copy of investigation 96-1534A into Strauss.

On May 20, 2019, Governor Mike DeWine issued Executive Order 2019-16D, establishing the Governor’s Working Group on Reviewing of the Medical Board’s Handling of the Investigation Involving Richard Strauss. The Medical Board should be the vanguard for protecting citizens from sexually predatory physicians, not only with regard to their medical licenses, but also in ensuring opportunity for effective prosecution of criminal behavior by working closely with law enforcement. Therefore, Governor DeWine charged the Working Group to:

- a. Investigate alleged violations of statutes or administrative rules regarding the failure to report crimes, specifically crimes involving sexual abuse by Richard Strauss, including any records maintained by the Medical Board;
- b. Explore whether the Medical Board thoroughly and appropriately investigated and responded to allegations of sexual abuse by Richard Strauss;
- c. Review the current policies, practices, and procedures of the Medical Board regarding the investigation and reporting of sexual abuse allegations to ensure that they are model policies, practices, and procedures;
- d. Examine the application of the statutory confidentiality requirements along with the need for transparency in State investigations;

The Working Group would undertake these charges in light of Governor DeWine’s recognition in the Executive Order that “all too often organizations and individuals failed to report allegations of sexual abuse that are received by them to law enforcement authorities.” The Executive Order further appreciated the need for justice, but not at the expense of survivors of abuse. That is, “it is of vital importance that all allegations of sexual abuse received by the Medical Board are reported to and investigated by law enforcement authorities,” and also that “identifying the victims of sexual abuse and linking them with the necessary services and treatment is essential in the recovery from the injuries inflicted on them.” In the words of the Executive Order, the Working Group’s approach and mission might be summed up as to analyze the Strauss case “not only as to what occurred, but as to what should have and can be done differently” so that the Medical Board may deter, detect, and proactively stop the next Strauss.

¹⁰ OSU has made the Report of the Independent Investigation: Sexual Abuse Committed by Dr. Richard Strauss at The Ohio State University available via link on the home page of the University’s website. The Report is currently available at: <https://compliance.osu.edu/strauss-investigation.html>. As of this date, the website indicates that the shared link to documents will be disabled on November 15, 2019.

WORKING GROUP STRUCTURE AND APPROACH

The membership of the Working Group comprised a cross-section of government, bringing varied expertise and experience. The Working Group included medical professionals, health and mental health professionals, law enforcement leaders, a victim advocate, and a former member of the Ohio House of Representatives. The members are:

- Tom Stickrath, *Chair of the Working Group and Director of the Ohio Department of Public Safety;*
- Lieutenant Colonel Kevin Teaford, *representative of the Ohio State Highway Patrol;*
- Lance Himes, *Chief Counsel and designee of the Director of the Ohio Department of Health;*
- Lori Criss, *Director of the Ohio Department of Mental Health & Addiction Services;*
- Dr. Mark Hurst, *former Medical Director and designee from the Ohio Department of Mental Health and Addiction Services, and current Medical Director and designee from the Ohio Department of Health;*
- Carol O'Brien, *Deputy Attorney General and designee of the Ohio Attorney General;*
- Sloan Spalding, *Chief of Staff and designee of the Ohio Auditor of State;*
- Amy Priddy, *Victim Advocate, Ohio Attorney General's Office;*
- Ron O'Brien, *Franklin County Prosecutor;*
- Dr. Kent Harshbarger, *Montgomery County Coroner;*
- Russell Martin, *Delaware County Sheriff;*
- Jeff Newton, *Chief of Police and Public Safety Director, University of Toledo;*
- Kelly Heile, *Chief of the Child/Sexual Assault Division, Butler County Prosecutor's Office;*
- Savalas Kidd, *Assistant Chief of Police, University of Dayton;*
- Dr. Patrick Oliver, *Director of the Criminal Justice Program at Cedarville University; and,*
- Michael Curtin, *former member of the Ohio House of Representatives.*

The Working Group held its initial meeting on May 29, 2019, the week following issuance of the Governor's Executive Order. The Working Group held eight additional meetings from June 6 through July 24, 2019. At its meetings, the Working Group interviewed participants in the Medical Board's 1996 investigation of Strauss as well as those with information pertinent to the investigation or current Medical Board practice, and discussed the investigation, the interviews, and the findings of the Working Group.

All interviewees appeared voluntarily at the invitation of the Chair of the Working Group. The Working Group is thankful for their participation, and the candor and seriousness with which they approached the Working Group and its charge. The following individuals who interacted with Strauss or were otherwise involved with the 1996 Medical Board investigation of Strauss appeared:

- Marcia Barnett, *retired, Medical Board Investigator in 1996;*
- K. Randy Beck, *retired, Medical Board Investigator in 1996;*
- William J. Schmidt, *Medical Board Investigation Supervisor/Assistant to the Director in 1996, and current Licensure Advisory Counsel;*

- Diann K. Thompson, *retired attorney, Chief Enforcement Coordinator for the Medical Board in 1996*; and,
- Anita M. Steinbergh, D.O., *former Medical Board Member, 1993-2018*.

John W. Rohal, Assistant Director in 1996, provided information by phone. Others identified as directly involved in the Medical Board's 1996 Strauss investigation are deceased. They were: Raymond Albert, Medical Board Member and elected Supervising Member overseeing the Strauss and other investigations; Dr. Thomas E. Gretter, Medical Board Member and elected Board Secretary overseeing the Strauss and other investigations; C. Jay Hunter, Area Supervisor over the primary Strauss investigator; and Lori S. Gilbert, the attorney who served as Enforcement Coordinator under Diann Thompson, and who the records indicate developed the plan to continue the Medical Board's case against Strauss.

Bridging the period from the Strauss investigation to today, the Working Group interviewed the following current Medical Board personnel:

- Michael Schottenstein, M.D., *President of the Medical Board*;
- Kim G. Rothermel, M.D., *Secretary of the Medical Board*;
- Bruce R. Saferin, DPM, *Supervising Member of the Medical Board*;
- A.J. Groeber, *Medical Board Executive Director*;
- Kim Anderson, *Medical Board Chief Legal Counsel*; and,
- Rebecca Marshall, *Medical Board Chief Enforcement Attorney*.

The Working Group also obtained materials from the Medical Board to aid in its analysis. The focus was on materials giving insight to the Board's decisions in and around 1996 and on its current policies and procedures. In some instances, materials existed for some but not all of a relevant time period. Materials available to the Working Group included:

- Medical Board investigations 96-1534A, 96-1534B, and 96-0999;
- January 1991 to December 2003 Memoranda of Disciplinary Actions;
- 1990-2003 Medical Board Members;
- Medical Board Members serving as Secretary and Supervising Member;
- 1998-2005 Organizational Charts;
- The State Medical Board of Ohio Disciplinary Guidelines (Rev. August 1999; December 1999);
- The State Medical Board of Ohio Disciplinary Guidelines (Rev. May 2001);
- The State Medical Board of Ohio Disciplinary Guidelines (Rev. January 2002);
- The State Medical Board of Ohio Disciplinary Guidelines (Rev. June 2018);
- Investigator's Manual (Rev. January 2019);
- State Medical Board of Ohio - Sexual Misconduct Investigation Process Changes (with Implementation Year);
- Secretary and Supervising Member Handbook (December 1999);
- Ohio Medical Board's Standard Complaint Process and Tracking;
- 1991 Complaint Procedures and Protocols;
- 1998 Complaint Procedures and Protocols;

- 2002 Complaint Procedures and Protocols;
- 2002 Medical Board of Ohio Annual Report;
- 2003 Medical Board of Ohio Annual Report;
- Agency Records Processing Map (Rev. 12.11.15);
- Lean Ohio Kaizen Event Fact Sheet; and,
- 2003.02.01 Kaizen Event Report Out.

The Working Group requested that OSU make available members of its outside investigative team responsible for the extensive investigation and subsequent May 15, 2019, report. Instead, the University made available and the Working Group interviewed:

- Anne K. Garcia, *Ohio State University Vice President for Wexner Medical Center Legal and Compliance and Senior Associate General Counsel*;
- Amy Golian, *Section Chief, Education Section, Office of Ohio Attorney General*;
- Charles Miller, *Assistant Attorney General, Office of Ohio Attorney General*; and,
- Kathleen M. Trafford, *Porter Wright Morris & Arthur LLP*.

Finally, in addition to interviews, the Working Group received presentations from a Working Group member and/or attorney for the Ohio Department of Public Safety, which houses and staffs the Working Group, on: (1) the role of victim advocacy in sexual abuse cases, and trends for identifying abusers and abusive behavior; (2) the State of Michigan’s response to revelations surrounding Larry Nassar; and, (3) legal concepts such as the criminal and administrative duties to report.

RECOMMENDATIONS

Over the years, the Medical Board had already made significant strides in addressing physician sexual impropriety before Strauss’ sexual abuse became public, and has reported to the Working Group that it is in the process of implementing further improvements. Set forth below are the consensus recommendations of the Working Group to the Medical Board, followed by bullet points with potential specific steps toward implementing that recommendation.

1. Duty to Report to the Medical Board. The Medical Board should identify any current Ohio medical license holders who had knowledge sufficient to form a belief that Strauss had violated the rules governing Ohio physician-licensees, but did not report that conduct to the Medical Board, so that the Board might investigate whether there was an actionable failure to report.

- The Board should review investigations relating to Strauss (96-1534A, 96-1534B, and 96-0999A) and the OSU report to identify current license holders who failed to report Strauss to the Medical Board in order to determine whether to initiate an investigation into that failure to report. The same course of action may be warranted in relation to other sexual impropriety, or illegal activity, cases in which the Board finds that historically it pursued an

action against the offending physician's license but did not investigate those who failed to report that behavior.

- On July 10, 2019, the Working Group sent a letter to the University asking that it provide an unredacted copy of its report to the Medical Board, and that it identify by name the numerous medical professionals identified in its report by title or description, only, who may have had information regarding Strauss' activity violating the rules governing Ohio physician-licensees. In response, the University provided the unredacted report to the Medical Board for the first time, but did not directly identify those described in its report.
- The Medical Board should develop an internal, mandatory reporting requirement for its staff – particularly, but not exclusively, investigators – to ensure that when any employee of the Board uncovers information suggesting that a licensee failed to report information sufficient to support a belief of sexual impropriety the employee must submit a report promptly to the his or her supervisor outlining the newly discovered information and recommending an investigation unless the failure to report is already the subject of or incorporated within an open investigation.
- The Medical Board maintains an anonymous hotline for reporting physician misconduct, including sexual impropriety. The Board should take prompt action to increase both public and licensee awareness of the hotline, prominently use its website to facilitate anonymous complaints, and should clarify that non-physicians can provide tips on potential misconduct, including criminal activity, of licensees.
- The Medical Board should require that physician continuing education requirements toward maintaining a medical license include training on the duty to report pursuant to Ohio Revised Code § 4731.224, including, as necessary, revising the Medical Board's rules contained in Ohio Administrative Code Ch. 4731-10, "Licensing; Continuing Education."
- The Medical Board should review North Carolina H.B. 228, Section 8, page 221, which created an affirmative duty for licensees to report suspected sexual misconduct, within 30 days.¹¹ These would include incidents of sexual impropriety that a licensee reasonably believes to have occurred with a patient. In North Carolina, as of October 1, 2019, licensees who fail to report such conduct would be subject to discipline, and individuals who made reports in good faith would be immune from civil liability for such reporting. The Medical Board shall review and consider appropriate Ohio-specific revisions to such duty that would bolster Ohio's sexual impropriety patient protection.
- The Medical Board should consider amendments to the application for a license or renewal of the license to include: (i) a checkbox by which the applicants signify that they acknowledge and understand the licensee's duty to report; and (ii) a checkbox for the applicants to disclose whether they have engaged in conduct prohibited by the Medical Board's rules regarding Sexual Misconduct and Impropriety (Ohio Admin. Code §§ 4731-26-01 to -03). This will reinforce the duty to report and effectively require periodic self-reporting.

¹¹ House Bill 228/SL 2019-191 can be found here: <https://www.ncleg.gov/BillLookup/2019/H228>

2. Law Enforcement. The Medical Board should develop by the end of calendar year 2019 a protocol to work consistently and closely with law enforcement upon receipt of allegations of sexual impropriety that may implicate criminal conduct, remaining mindful of administrative procedures, constitutional protections against self-incrimination, confidentiality, and survivor-centered and trauma-informed investigations.

- The Working Group recommends that the Medical Board's plan include:
 - A plan to establish meaningful ties to local law enforcement in areas of the state having the highest incidence of sexual impropriety investigations, including with established victim advocacy programs in those agencies and Sexual Assault Response Teams (SARTs);
 - Instruction to contact law enforcement upon the opening of a sexual impropriety investigation to determine whether law enforcement has received or is investigating allegations against the subject of the Medical Board's investigation;
 - Guidance on when to involve law enforcement or the prosecutor's office so that the dual purposes of law enforcement conducting a criminal investigation and the Medical Board conducting an administrative investigation are best served; and,
 - Medical Board staff training in recognizing criminal sexual abuse, which is not a substitute for consulting law enforcement or local prosecutors.
- Early involvement of law enforcement is critical where potential criminal conduct is detected, both to gather information for the Medical Board investigation as well as to aide law enforcement to identify and investigate criminal activity. As a result, depending upon the nature of the conduct, victims, and specific circumstances of each case, the Medical Board's protocol must allow for its employees to exercise sound investigative judgment on when to diverge from that protocol and contact law enforcement immediately and directly, without risking internal or disciplinary reprimand.
- The Medical Board expressed interest in amending the sexual battery statute(s) in Revised Code Chapter 29 so that a violation in the context of certain physician-patient relationships constitutes criminal conduct by the nature of that relationship. The Working Group recommends that the Medical Board pursue this and other initiatives to better define and allow effective prosecution of criminal sexual conduct by physicians, including, for example, extending statutes of limitation and defining physician criminal conduct. Additionally, the Medical Board should review recent changes to North Carolina law enacted August 1, 2019 from House Bill 228, Part VI, beginning on page 20, which created a new criminal offense, punishable as a felony for sexual contact or penetration under pretext of medical treatment¹². A similar statute in Ohio would serve to deter physicians from this type of felonious conduct in the future.
- While the Working Group focused on the Strauss investigation and the above recommendations focus on investigating criminal sexual conduct, the Medical Board is encouraged to apply the lessons learned and techniques developed to include law enforcement in any case in which illegal activity is suspected or uncovered.

¹² House Bill 228/SL 2019-191 can be found here: <https://www.ncleg.gov/BillLookup/2019/H228>

3. Quality Assurance. The Medical Board should implement a practice of quality assurance not only to ensure that an investigation is opened when it should be, but to review the decision of whether the investigation merits moving from investigation to enforcement against the physician’s license.

- The Medical Board should access available resources by entering into a consulting agreement with the Office of Internal Audit in the Office of Budget and Management to ensure its internal controls are model policies and to suggest process improvements where necessary. Further, the Medical Board should engage the Auditor of State to perform a compliance and/or performance audit of the Medical Board’s adherence to its own standards regarding investigation of sexual impropriety allegations.
- The Medical Board should develop a practice to regularly review the decisions, or a meaningful percentage thereof, made by the Secretary and Supervising Member to close a sexual impropriety case without investigation or to close a case after investigation and without referral for enforcement. That review should include legal staff, investigative staff, and an internal or outside victim advocate.
- The Medical Board should consider a review of the manner in which investigative reports are delivered to enforcement attorneys, and whether and how to deliver them to Board Members other than the Secretary and Supervising Member involved in approving them for enforcement, so that the Board, as a whole, is informed at least of the basis for closing sexual impropriety cases even if not informed of the identity of the subject of the allegation.
- The Medical Board should continue its practice of reviewing aging cases and reviewing the time taken to complete investigations, not to the detriment of the quality of those investigations, but to ensure that a case is investigated and any citation issued promptly, and never again permitted to languish inactive.
- The Medical Board should review the practices of comparable state medical boards, to assess the use of a similar two-member team to oversee investigations, and to identify feasible quality assurance methods.

4. Confidentiality and Transparency. The investigation confidentiality afforded in Ohio Revised Code § 4731.22(F)(5) should not be a shield from oversight of inappropriate inaction such as that in the Strauss investigation. The Medical Board should take steps within the current statute, and support legislative amendment, to allow greater transparency within the Board and with the public, and be prepared to report back to this Working Group by Tuesday, October 1, 2019 on those efforts.

- Effective in 1999, the General Assembly amended § 4731.22(F)(5) to permit sharing the investigation with law enforcement and other regulatory agencies. The Working Group supports the Medical Board’s proposal to amend it further to replace “governmental agencies” with “governmental entity” to help alleviate unnecessary definitional restrictions on the Board’s permission to share investigative information.
- In the Strauss case, the enforcement and internal tracking records that may have existed would have provided accountability for the Board’s inaction. The Working Group recommends that the Medical Board make public its internal materials that do not themselves constitute a “report required to be submitted to the board under this chapter, a complaint, or information received by the board pursuant to an investigation or pursuant to an inspection . . .” under § 4731.22(F)(5) when closing a case without formal action.

- The Working Group recommends a statutory change to allow the President of the Board, or designated Member(s), to authorize the release of an investigation, subject to appropriate redaction, when in his or her professional judgment, disclosure of such information would avert or minimize a threat to public health or safety.
- The Working Group recommends a statutory change that would permit the Board, or designated Member(s), to authorize the release of investigative information, subject to appropriate redaction, for good cause, specifically including upon request of a law enforcement agency.
- The Board should document and disclose the reason for closing a case after investigation when the decision is made not to pursue formal action, and publicly disclose the existence of and status of pending cases.
 - Pursuant to Ohio Revised Code § 4731.22(F)(6), the Board reports quarterly on case disposition. For closed cases, the report requires: (a) case number; (b) type of license or certificate; (c) a description of the allegations contained in the complaint; and, (d) the disposition. The Working Group recommends adding sub-part “e” to this list, requiring disclosure of the reason for closure for any case investigated and closed without formal action.
 - In addition, under § 4731.22(F)(6), the Medical board is required to quarterly report how many cases are still pending. The Working Group recommends adding additional descriptors about the pending cases, including the date the complaint was received or opened, the case number assigned, the type of license or certificate to practice, if any, held by the individual against whom the complaint is directed, a brief categorical description of the type of complaint as alleged and a requirement that it include “. . . for any investigations that remain pending after one year, the reasons the investigations remain pending.”
 - While the Board should pursue statutory changes to this effect, the current statute should not prohibit the Board from taking these steps immediately.
- The Working Group recommends a time-limit on confidentiality under § 4731.22(F)(5), or, at least, the confidentiality reserved to the Board’s investigation materials, with continued protection of patient and other information that is confidential regardless of its inclusion in an investigation. Such limitations may include a provision to make the report of investigation available, subject to appropriate redaction, once formal action is taken against a physician-licensee.
- As part of its October 1, 2019 report, the Medical Board shall make any additional recommendations to the Working Group which would allow for more transparency in its investigations and the closure of complaints when no action is taken by the board, including changes to § 4731.22(F)(5) and the viability of a sunset to investigative confidentiality.

5. Board and staff structure and process. The Medical Board should review the current board structure and workflow to ensure that its processes are appropriate for its work. In addition, the Medical Board should analyze its current staffing divisions and make suggestions that would improve its work.

- The Medical Board should review and compare the Board’s number, structure and processes to other appropriately sized state medical boards, using available national membership resources as examples where appropriate, in order to determine whether there are recommendations for changes to the Medical Board of Ohio’s size, membership, structure or member-involved processes. This review and recommendation should include a review of the existing roles of the Supervising Member and Secretary. The review should also inform whether other medical boards include member(s) from law enforcement.
- The Working Group acknowledges pronounced conflict between the Medical Board’s investigative staff and both its Members and its enforcement staff. The Medical Board should evaluate the conflict(s) between its investigative and enforcement staff, as well as investigative staff and management, and provide suggested resolution(s) that would encourage all staff to work collaboratively, as the Board cannot achieve its best work for protecting the public when tensions between these factions inhibit meaningful collaboration toward their shared goal.

6. Sexual Impropriety Investigations. The Medical Board should use victim advocates in the investigative process. Its investigative and enforcement staff, at a minimum, should receive training on, and tools to address, the unique aspects of sexual impropriety case investigations.

- The Working Group recommends, and the Medical Board indicated that it has begun, developing victim advocacy expertise internally, and identifying the victim advocacy network(s) available in law enforcement and prosecutors’ offices, including investigators becoming involved in area Sexual Assault Response Teams (SARTs) where they exist.
- The Medical Board should build upon the training its staff received in May 2019 on this subject, and by the end of calendar year 2019:
 - Develop annual training goals for investigative and enforcement staff on survivor-centered and trauma-informed investigative techniques;
 - In consultation with a victim advocate, finalize the proposed “Sexual Misconduct Complaint Protocol” presented to the Working Group; and,
 - In consultation with victim advocates and investigative professionals, update the investigation manual accordingly, allowing for modern investigative practices that take into account the survivor’s needs and preferences, such as
 - eliminating administrative closure of sexual impropriety cases when a survivor fails to come forward initially,
 - allowing multiple interviews and conducting the interviews at the times of the survivor’s or witnesses’ choosing (including outside of regular business hours or the regular workweek),
 - removing the requirement that meetings with complainants and witnesses in sexual impropriety investigations must be conducted in a neutral location, and

- eliminating the provision that finds a survivor’s refusal to meet at a neutral location or provide information via remote means “adequate grounds for closure.”
- The Medical Board should consider establishing specialized team(s) for sexual impropriety cases, and such team(s) should consult with the Ohio Attorney General’s Office to develop the approach to both administrative matters and criminal referrals.

7. Considerations for Additional Study or Information by the Medical Board.

- In light of the Working Group’s review and recommendations, the Medical Board should consider the following to further ensure reporting misconduct:
 - The impact of amending Ohio Revised Code § 2921.22, “Failure to report a crime or knowledge of a death or burn injury,” specifically to include a duty to report certain criminal acts by physicians practicing in Ohio regardless of whether they rise to the level of a felony; alternatively, whether an Ohio criminal law should be created or existing law amended to raise certain criminal acts by physicians to the felony level, thus subjecting them to mandatory reporting under the current version of § 2921.22.
 - Regardless of the conclusion above, the impact of replacing the “knowing” standard in § 2921.22 with one similar to Ohio Revised Code § 2151.42 which requires “anyone who knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect that” a reportable offense by the physician has occurred.
 - The impact of the Medical Board reporting allegations of a physician-licensee’s sexual impropriety to other state medical boards (such as through the National Practitioner Data Bank or other body, subject to timing and other reporting criteria) even if the Medical Board has not taken any enforcement action against a licensee, and consider the constitutional and legal protections surrounding such action.

In addition, the Medical Board Executive Director presented a series of additional requests or suggestions to the Working Group on areas that the Medical Board itself would like to pursue in order to strengthen its ability to address, among other things, sexual impropriety allegations. They included:

- Amending Ohio Revised Code § 4731.22 to permit the Board to proceed to citation against a physician’s license based solely on an indictment;
- Amending Ohio Revised Code § 4731.22(O) to allow the Board the ability to fine licensees who are required to complete non-disciplinary remedial education but fail to do so;
- Amending Ohio Revised Code § 4731.01 to increase the Medical Board membership by authorizing the Governor to appoint at least one additional “consumer” Board Member, to serve a term concurrent with the Governor’s term; and,
- Amending Ohio Revised Code Chapter 23 in order to provide the Medical Board access to peer review information.

The Working Group does not take a position on the Medical Board’s legislative agenda or proposed statutory changes. It certainly does, however, encourage the Medical Board to pursue every avenue it identifies, and to work whenever possible with its licensees, hospitals and other medical providers employing and extending privileges to physician-licensees, the Ohio Attorney General, and law enforcement to further develop its proposals, and to identify feasible and meaningful methods to ensure

the safety of the patients of its licensees. The Working Group extends an open invitation for the Medical Board to present updates on its initiatives at any future meeting of the Working Group.

8. Considerations for Additional Study or Information by Ohio Health Care Boards.

- The Working Group believes that the lessons gleaned from the Strauss investigation and this Group’s findings may be generally applicable in some form to other boards regulating the licenses of health care professionals or other health care fields.
- The Working Group recommends that the health care boards be directed to submit to this Working Group, or other entity created or designated by Governor DeWine, a report that details whether and how, through statute, rule and practice, each board:
 - Requires licensees to report violations of self and fellow licensees, and how the board tracks that information to encourage active self-regulation of licensees;
 - Engages law enforcement with its investigative staff for violations that have both licensing and criminal implications;
 - Oversees the investigative process in licensing cases, including using a subgroup of board members, and how the board ensures that case closures without investigation or citation are adequately documented and for good cause;
 - Balances the need for confidential investigations with the investigative staff remaining accountable to the board and the board remaining accountable to the public, specifically including the rationale for allowing or not allowing disclosure or public inspection of investigative files once closed; and,
 - Incorporates, if applicable, survivor-centered and trauma-informed investigative techniques.

Prior to January 20, 2019, the Working Group or other entity will convene leadership from all appropriate Ohio Health Care Boards to advise the Working Group on best practices that are relevant to all such boards.

NEXT STEPS

The Working Group looks forward to its continuing role outlined in paragraph 7 of Governor DeWine’s Executive Order 2019-16D to meet periodically to carry out the above recommendations and to provide additional guidance. In anticipation of the Working Group reconvening, the Working Group requests that by Tuesday, October 1, 2019, the Medical Board be prepared to report a response to Recommendation 4, and that by Friday, November 1, 2019, the Medical Board be prepared to report to the Working Group on its progress and response regarding Recommendations 1-3 and 5-7 in this report.

APPENDICES

- Appendix 1. Governor Mike DeWine's Executive Order 2019-16D
- Appendix 2. Redacted Medical Board Investigation 96-1534A
- Appendix 3. Redacted Medical Board Investigation 96-1534B
- Appendix 4. Redacted Medical Board Investigation 96-0999
- Appendix 5. Report Fig. 1 – Event Comparison Timeline
- Appendix 6. Summary timeline of Medical Board Investigation 96-1534A
- Appendix 7. Paperwork relating to Strauss' June 20, 1996 Ohio medical license renewal
- Appendix 8. Medical Board charts outlining investigative processes over time, and current plans for improvement
- Appendix 9. Minutes of May 23, 2019 special meeting of the State Medical Board of Ohio



MIKE DEWINE
GOVERNOR
STATE OF OHIO

Executive Order 2019-16D

Governor's Working Group on Reviewing of the Medical Board's Handling
Of the Investigation Involving Richard Strauss

WHEREAS, as revealed in the "Report of the Independent Investigation: Sexual Abuse Committed by Dr. Richard Strauss at The Ohio State University," it is clear that all too often organizations and individuals failed to report allegations of sexual abuse that are received by them to law enforcement authorities; and

WHEREAS, the Report of the Independent Investigation references an investigation conducted by the Medical Board of Ohio which involved Richard Strauss. The Report of the Independent Investigation does not reveal whether the Medical Board ever received allegations that Strauss sexually abused his patients, as references to the Board's records are redacted; and

WHEREAS, historical reports of organizational and institutional failures to appropriately act such as the Report of the Independent Investigation, should be reviewed and analyzed not only as to what occurred, but as to what should have and can be done differently as well as to ensure that today's policies and procedures are the best they possibly can be; and

WHEREAS, it is of vital importance that all allegations of sexual abuse received by the Medical Board are reported to and investigated by law enforcement authorities; and

WHEREAS, identifying the victims of sexual abuse and linking them with the necessary services and treatment is essential in the recovery from the injuries inflicted on them;

NOW THEREFORE, I, Mike DeWine, Governor of the State of Ohio, by virtue of the authority vested in me by the Constitution and the laws of the State of Ohio, do hereby order and direct that:

1. The Governor's Working Group on Reviewing of the Medical Board's Handling of the Investigation Involving Richard Strauss ("Working Group") is hereby created to:
 - a. Investigate alleged violations of statutes or administrative rules regarding the failure to report crimes, specifically crimes involving sexual abuse by Richard Strauss, including any records maintained by the Medical Board;

- b. Explore whether the Medical Board thoroughly and appropriately investigated and responded to allegations of sexual abuse by Richard Strauss;
- c. Review the current policies, practices, and procedures of the Medical Board regarding the investigation and reporting of sexual abuse allegations to ensure that they are model policies, practices, and procedures;
- d. Examine the application of the statutory confidentiality requirements along with the need for transparency in State investigations;
- e. Prepare a report with the findings of the investigation and with recommendations detailing best practices to achieve full reporting of sexual abuse allegations; and
- f. Should any unreported criminal activity be found that it be referred to the appropriate law enforcement agency.

2. The Working Group shall be comprised of:

- a. The Director of the Ohio Department of Public Safety as Chairperson of the Working Group;
- b. A representative of the Ohio State Highway Patrol;
- c. A designee of the Director of the Ohio Department of Health;
- d. A designee of the Director of the Ohio Department of Mental Health & Addiction Services;
- e. A designee of the Ohio Attorney General;
- f. A designee of the Ohio Auditor;
- g. A person who is professionally involved in victim advocacy;
- h. The Franklin County Prosecutor or his designee;
- i. The Montgomery County Coroner;
- j. A current or former Sheriff;
- k. A current or former Police Chief; and
- l. The Department of Public Safety shall select up to six additional members, in consultation with the Office of the Governor, from State and local law enforcement and local prosecuting attorneys.

3. The Working Group shall be located within and staffed by the Department of Public Safety, which shall provide the support and resources necessary for the Working Group to fulfill its obligations as outlined in this Executive Order, in coordination with the Office of the Governor. This shall include space to gather and consider information necessary for developing the recommendations and report called for in this Order.

4. Members of the Working Group shall serve without compensation.

5. All Agencies, Boards, Commissions and State Institutions of Higher Education shall cooperate and provide assistance as needed to the Working Group in performing its functions.

6. No later than August 1, 2019, the Working Group shall submit its written report detailing its investigation and recommendations.

7. Upon completion of these recommendations, the Committee shall meet no less than quarterly to assess and provide guidance to carry out the recommendations.

I signed this Executive Order on May 20, 2019 in Columbus, Ohio and shall expire on June 1, 2020.


Mike DeWine, Governor

ATTEST:


Frank LaRose, Secretary of State



Filed on MAY 20, 2019
Per Jenny M. [Signature]
In the Office of the Secretary
of State at Columbus, OH
FRANK LaROSE
Secretary of State

ENFORCEMENT
Medical Board

Issues
 Search
 Add New
 Tickler
 Work Queue
 Work Queue Sort
 List Active
 Follow-Up List

Enforcements
 Search
 Add New
 Tickler
 Work Queue
 Work Queue Sort
 List Active
 Follow-Up List

Legacy

Issue View Screen

Case	1995-96153401	Date Received	07/15/1996	Audit Documents Entry Items Notes Enforcement
Status	CLOSED	How Received	Data Conversion	
Respondent ID	3037810	Receiving Board	MED	
Respondent	STRAUSS, RICHARD - HARRY	Receiving	MED - Issue Worker	
Updates	Unavailable - Converted to eLicense 3.0	Department		
Initiator ID	4005110	Received By	LEGACY DATA	
Initiator	BRADY, JUDY	Date Reviewed	07/31/1996	
		Category	MED - Data Conversion	
		Priority	ZZZ-E - Sexual Violations	
		Docket/AG Number		
Alleged Issues		SEX - Sexual improprieties		

Complaint:

Other Participants

No additional participants found

Resolution

Department	MED - Issue Worker	Found Issues
Worker		Resolution Type
Date Closed	01/25/2002	MED-END-Enforcement-Disposed
		Last Worker:

Resolution:

Action Items

Type	Assigned to	User	Created	Due	Activity	Completed	Letter	Envelope
END - Enforcement - Disposed	MED - Issue Worker	VAX	07/31/1996		01/25/2002	01/25/2002		
CIT - Assigned to Enforcement	MED - Issue Worker	Gilbert, L	07/31/1996		01/03/1997	01/25/2002		
CIT - Assigned to Enforcement	MED - Issue Worker	Gilbert, L	07/31/1996		01/03/1997	01/03/1997		
SEI - Review by Sec & Supv Mem	MED - Issue Worker	VAX	07/31/1996		12/05/1996	01/03/1997		
INV - Investigation	MED - Issue Worker	Beck, R	07/31/1996		08/20/1996	12/05/1996		
SEC - Initial Review by Sec & Supv Mem	MED - Issue Worker	VAX	07/31/1996		07/31/1996	08/20/1996		
INI - Complaint Received	MED - Issue Worker	VAX	07/31/1996		07/15/1996	07/31/1996		

Issue File Year:
 After the issue file
 year to search for

- [Close Window](#)
- [Print This Page](#)
- [Expand All | Collapse All](#)

1996-96153401

Number	1996-96153401	Status	Closed
Type	Complaint	Resolution Code	Other
Board	Medical Board	Resolution - Historical	MED-END-Enforcement-Disposed
Complaint Source	Other	Submitted Date	7/15/1996
If Other, Initiated By:	Data Conversion	Closed Date	1/25/2002
Route To		Owner	Data Administrator
Related Case		Owner Start Date	
Marked for Deletion		Days Owned	
ComplaintIdntCredentialIdnt		Name of Business at the Address	
License Type		License Renewal Number	
License Number			
Start Date			

Complainant Information

Complainant Prefix		Complainant Email	
Complainant Full Name	BRADY, JUDY	Complainant Phone (Main)	6142920110
Complainant First Name		Complainant Phone (Mobile)	
Complainant Middle Name		Complainant Phone (Alternate)	
Complainant Last Name		Complainant Mailing Address	OSU STUDENT HEALTH SERVICES 1875 MILLIKEN ROAD
Complainant Suffix		Complainant City	COLUMBUS
		Complainant State/ Prov.	Ohio
		Complainant Zip/ Post Code	43210-2200

Respondent Information

Account: RICHARD STRAUSS
 Contact: RICHARD STRAUSS
 License Number (Respondent): 35.042299
 Related License Type: Doctor of Medicine (MD)
 Respondent Email: NULL
 Respondent Phone (Main): NULL
 Respondent Phone (Mobile):
 Respondent Phone (Alternate):
 Respondent Mailing Address:
 Respondent City:
 Respondent State/ Prov.:
 Respondent Zip/ Post Code:

Complaint Information

End Date:
 Description:
 Willing to testify?
 Patient Name:
 Patient Date of Birth:
 Reported to other Agency?
 Agency Name:
 Other Agency Description:

Triager Information

Alleged Incident:
 Alleged Issues - Historical: SEX - Sexual improprieties
 ASAP: ZZZ-E - Sexual Violations
 UNC Release Letter Sent:
 UNC Response Requested: MED - Data Conversion

Licensure Triage Section

Request NPDB

Background Check Pending

Response Required

Triage Notes

90 Day Notice Required

90 Day Notice Sent

Request LEADS Report

Investigation Information

Priority Code

ROI Due Date

Date Complaint Sent to Investigator

Days Open

Enforcement Information

Priority Code

Enforcement Due Date

Initial Date Assigned to Enforcement

Standards Review Information

Standards Review Status

Standards Review Sub-Status

Subpoena Due Date

Review Due Date

System Information

Created By Data Administrator, 2/26/2016 2:58 AM

Record Type Medical_Board_Complaint

Last Modified By Data Administrator, 3/10/2016 12:14 AM

Historical 

Submissions

Create New Submission

Actions	Title	Description	Submission Time	Acknowledged	Visibility	Uploads	Status	Complete
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Attachments

Actions	Attachment Name	Application Type	Doc Uploaded to Onbase	Application Number	Created Date	Board	Document Type
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Activity History

END - Enforcement - Disposed

Group	Type
Converted Action Item - No longer applicable	Status Completed
Due Date	1/25/2002
Assigned To	Data Administrator
Comments	

SEC - Initial Review by Sec & Supv Mem

Group	Type
-------	------

Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **8/20/1996**
 Assigned To **Data Administrator**
 Comments

INI - Complaint Received

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **7/31/1996**
 Assigned To **Data Administrator**
 Comments

INV - Investigation

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **12/5/1996**
 Assigned To **Data Administrator**
 Comments

CIT - Assigned to Enforcement

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **1/25/2002**
 Assigned To **Data Administrator**
 Comments

SEI - Review by Sec & Supv Mem

Group
 Type

8/21/2018

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **1/3/1997**

Assigned To **Data Administrator**

Comments

CIT - Assigned to Enforcement

Group

Type

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **1/3/1997**

Assigned To **Data Administrator**

Comments

Complaint History

2/27/2016 11:25 AM

User **Data Administrator**

Action **Deleted Administrative Triage in Route To.**

2/26/2016 2:58 AM

User **Data Administrator**

Action **Changed Route To to Administrative Triage. Created.**

LSE
Strauss, Richard H., M.D.
NAME

96-1534(A)
COMPLAINT NUMBERS AND DATES

STATE MEDICAL BOARD
ENFORCEMENT FILE

TEG
SECRETARY

RJA
SUPERVISING MEMBER

Strauss

Complaint involves:	Strauss, Richard MD Internal Medicine Columbus, OH (at OSU)		
License status & expiration date	Inactive since 1998		
Complaint #: type; priority code	#96-1534A	Sex	E
EC assigned to case:	Lori		
Additional complaints on file	none		
Mantrk reports on file:	none		
Prior Board actions:	none		

Case Notes:

1. Complaint - male student, alleges unapp. genital exam as part of sports physical. Inv. showed OSU Student Health Services had received at least 2 similar earlier complaints & they did not renew Dr's contract. Events occurred in 1995/1996; unv. id'd some of the students. DR'S license lapsed in 1998. Would have to apply for restoration.

Secretary/Supervising Member Decisions:

<input checked="" type="checkbox"/> Close <i>FR</i>	Secy <i>Dr 1/25/02</i>	Supervising Member <i>Dr 1/25/02</i>
<input type="checkbox"/> follow up investigation	Secy _____	Supervising Member _____
<input type="checkbox"/> Enforcement	Secy _____	Supervising Member _____
<input type="checkbox"/> Other	Secy _____	Supervising Member _____

comments:

No letters

1-28-02 cc: KRB

01/22/02

MDMAST

17:03:31

1) Name: STRAUSS (last) RICHARD HARRY (first)
 Addr1: B 101 STARLING-LOVING HALL
 Addr2: OHIO STATE UNIVERSITY HOSPITAL
 City: COLUMBUS St: OH
 County: 25 FRANKLIN Zip: 43210-0000

Filenum: 35-0422991

Addr1:
 Addr2:
 City: St:
 County: 00 Unknown Zip: 00000-0000

3) SRS Status: 5I INACTIVE L
 Issue Date: 06/20/96
 Expiration Date: 09/30/98

2) Sex: M Birth: 07/30/38 Deceased: 00/00/00
 SSN: Redacted City: CHICAGO
 St: IL Country:
 How Issued: N END (NATL BDS) Date: 07/11/78
 Specialty: IM INTERNAL MEDICINE

Cert. Mailed Date: 00/00/00 MEEP: 00/00/00
 Graduation: 06/12/64 School: 01602 UN OF CHICAGO, PRITZKER SM, CHICAGO
 This record has No Malpractice Report(s)!!! PRESS<Return>

1 Complaint: male student alleges inapp. genital exam as part of sports physical. Complained to OSU Student Health Services - they had rec'd ^{at least} 2 earlier, similar complaints. Did not renew Dr's contract.

Events: 1995/1996. Investigation id'd some of the students.

Dr's lic lapsed in 1998. Would have to apply for ~~renewal~~ restoration.

01/22/02

SEARCH

17:02:48

1 961534A STRAUSS, RICHARD H	By: BRADY, JUDY	Inv: KRB
Ty: SEXUAL IMPROPRIETIES	Stat: ASSIGNED TO ENFORCEMENT	
2 961534B OSU HOSPITALS	By: OSMB/RAY BUMGARNER -	Inv: KRB
Ty: FAILURE TO REPORT	Stat: INVESTIGATED/DISPOSED	

Enter: LINE NO....To Show Record, N....For Next Page, A....Abort

CASE REVIEW FOR NEW ASSIGNMENTS
(To be completed within one (1) month of assignment)

- Interval Med.
- born 1933
- act. license
- Rudy Beck, Jr.
- licensed 1972

NAME RICHARD H. STRAUSS, M.D.

ADDRESS B 101 Starling-Loving Hall
Columbus, OH 43210

Complaint Numbers: 96-1534n (SEX)

Enforcement Coordinator: LSG

Date Assigned: 1/3/97

Case Type: Sexual Improprieties

Summary of Complaint: It is based upon multiple allegations that Dr. Strauss has conducted inappropriate exams of male patients' genitalia, (exam too long in duration, not necessary, & involving fondling) + has made inappropriate comments toward male patients at OSU's Student Health Center. It is further alleged that

Anticipate Action: he has inappropriately examined male members of certain sports while serving as the team's physician.
Further Investigation: no records needed Coordinate with other Issues re: disclosure of confidential pt info by Dr also exist.

Deposition: _____ Agencies: _____

Subpoena Patient Records: _____ Script sort: _____

Expert Witness: _____ Evaluation: _____

Other: _____

Comments: Dr's contract for his services at the OSU Student Health Clinic was not renewed in 1996 after several complaints. He has now opened a Men's Clinic on 5th in Grandview + is advertising in OSU Student Newspaper.

Suggested Priority Code: E

Signature of Enforcement Coordinator: Jori S. Gilbert

Date: 1/6/97

CHIEF ENFORCEMENT COORDINATOR:

OK:

Let's Discuss: _____

Initialed: LSG

Priority Code: _____

Date: 2/6/97

STATE OF OHIO MEDICAL BOARD
COMPLAINT TRACKING

TIME: 10:41:10

1. NAME: STRAUSS, RICHARD H LICENSE: MD LICENSE NO: 042299
COMPLAINT TYPE: SEX-SEXUAL IMPROPRIETIES TYPE DATE: 07/31/96
:
:
COMPLAINT STATUS: CIT-ASSIGNED TO ENFORCEMENT STATUS DATE: 01/03/97
SUPERVISE BD MEM: RJA-RAYMOND ALBERT
BOARD SECRETARY: TEG-THOMAS E. GREYER, MD
INVESTIGATOR: KRB-KEVIN R. BECK
ENFORCEMENT CO: LSG-LORI S. GILBERT PRIORITY CODE: E
COMPLAINT NUMBER: 961534A NOTE:

2. SOURCE TYPE: -
COMPLAINANT NAME: BRADY, JUDY LIC.RPT: N
ADDRESS: OSU STUDENT HEALTH SERVICES
ADDRESS: 1875 MILLIKEN ROAD
CITY: COLUMBUS STATE: OH ZIP: 43210-22
PHONE: (614)292-0110 ADDRESS UPDATED: 07/31/96

Press PF2 For Help

TO returned message
FROM OSU
OF
EXT
MESSAGE
S
A
G
G
E
DATE 4/25/97 TIME 10:38 AM
AREA CODE -10:42 PM
NO
EXT
→ Dr Strauss brought letter to saying we dropped all charges against him. He now wants them to reopen case re his employment.
→ Said I or someone else would get back to her but cannot confirm
SIGNED [Signature]
PHONED CALL BACK RETURNED CALL WANTS TO SEE YOU WILL CALL AGAIN WAS IN URGENT
closing of a complaint

292-8993-

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: Diann K. Thompson, Chief Enforcement Coordinator

FROM: John W. Rohal, Assistant Director 

DATE: December 18, 1996

RE: Richard H. Strauss, M.D.
O.S.U. Hospitals
Complaint # 96-1534 A&B

Attached are the enforcement files of Doctor Strauss and O.S.U. Hospital which are forwarded for assignment to Cite.

JWR:jh

cc: K. Randy Beck, Investigator
C. Jay Hunter, Area Supervisor

Richard H. Strauss

Charles D. Stienecker, M.D.
President
Wapakoneta, Ohio

Nora M. Noble
Vice-President
Newark, Ohio

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Board Member
Cincinnati, Ohio

Bradley K. Sinnott, Esq.
Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

MEMORANDUM

TO: William J. Schmidt, Assistant to the Director *WJS*
FROM: Marcia L. Barnett, Investigator *MB*
DATE: November 27, 1996
RE: Richard H. Strauss, M.D.
Complaint No. 96-1534A

I returned a telephone call to _____ yesterday. He was inquiring about the status of a complaint lodged against him by Dr. Strauss (96-0999A). During our discussion, _____ mentioned that Dr. Strauss had opened a "men's clinic" on 5th Avenue in Grandview.

_____ said that he has seen advertisement for the clinic in The Ohio State University student newspaper, *The Lantern*. He said that the advertisement indicates that there is more than one physician running the clinic and that the clinic offers a discount to University students. _____ believes the men's clinic may have opened around September of 1996, when the advertisements first appeared.

_____ said that he called the men's clinic and was surprised that Dr. Strauss answered the telephone. Dr. Strauss apparently did not recognize _____ voice and answered several questions about his clinic. _____ said that Dr. Strauss told him that he was the only doctor "at this time" running the men's clinic.

cc: Randy Beck, Investigator

12-5-96

STATE MEDICAL BOARD OF OHIO
REPORT REVIEW FORM

COMPLAINT NO. 96 1534 A/B

COMPLAINT TYPE:
SEX. FTR

COMPLAINT INVOLVES:

Richard H. Strauss, M.D.
OSU - OSF

COMMENTS

To Enforcement to possible
develop a cite. RA 12/15/96

12/15/96 to Enforcement for cite #2

EC 12/11/96 48. RICHARD H. STRAUSS, MD - CITE

IF OFFICE CONFERENCE - REASON: _____

TO ACCOMPLISH: _____

STATE MEDICAL BOARD
REPORT OF INVESTIGATION

Complaint No. 96-1534AB		Date Of Complaint 8-22-96		Type Of Complaint SEX	
Complainant: Last Name Brady		First Judy	Middle	Sex	Race Dob/Age
Address: Student Health Services 1875 Milliken Rd., Columbus, Ohio 43210				Phone 292-0110	
Complaint Involves: Last Name Strauss		First Richard H.	Middle	Sex	Race Dob/Age
Address: 1501 Doone Rd. Columbus, Ohio 43221				Phone 488-1094	
<p>INVESTIGATIVE ACTION</p> <p>This investigation is the result of a complaint filed against Dr. Strauss for sexual misconduct. The complaint was received on August 23, 1996.</p> <p>According to the initial complaint, Dr. Strauss was suspended from clinical practice at the OSU Student Health Services for performing inappropriate physical examinations of male students. On January 5, 1996 a male student complained about an exam that he received from Dr. Strauss. The complaint further states that a "Due Process" Hearing was held in June of 1996 to review the January incident and other previous incidents. Dr. Strauss also performed physical examinations for the Department of Athletics and has been asked to provide this service any longer. The complainant feels that Dr. Strauss is homosexual; however there is no proof to this effect.</p> <p>On August 28, 1996 I received from Investigator Marcia Barnett information the Dr. Strauss submitted to justify his examinations. Dr. Strauss complained (96-0999A) about _____ of the Student Health Services, and the complaint is assigned to Ms. Barnett for investigation. In the information Dr. Strauss identifies one of the patients as _____</p> <p>On August 29, 1996 I met with Judy Brady, Assistant Director for Administration, OSU Student Health Services, to discuss the complaint. She said that there were three incidents that prompted the suspension of Dr. Strauss and explained each one.</p> <p>The incident involving male student #1, occurred on December 18, 1994 and</p>					
Investigator: K. R. Beck <i>LR</i>			Date: 12-4-96		Hours: 60
Witness: Last Name		First	Middle	Sex	Race Age
Address:				Phone	
Witness: Last Name		First	Middle	Sex	Race Age
Address:				Phone	

RE: Richard H. Strauss, M.D.

Complaint No: 96-1534 A&B

Date: August 22, 1996

was reported on January 3, 1996. Student #1 came to the center treatment of a sexually transmitted disease (STD) and requested a vinegar test for genital warts. Dr. Strauss refused to do the vinegar test and the patient to stop taking all other medications and not to see another doctor. During this visit Dr. Strauss taught the patient how to do a self testicular exam. After the first visit the patient refused to return to Dr. Strauss citing unprofessional conduct by the doctor. Ms. Brady said that the student had a very difficult time discussing the incident and was not interviewed for additional information.

The incident involving student #2 occurred on January 5, 1995 and was reported on January 6, 1996. The student came to the center for treatment of a lump in the breast. Dr. Strauss said that the lump was just breast tissue and men could not get breast cancer. Dr. Strauss stated to the student that he would like to work with AIDS patients and then asked the student if he was gay. Dr. Strauss then proceeded to do a genital and rectal exam. Dr. Strauss never asked the student if he had ever had a genital exam even when the student told Dr. Strauss that he is being followed by his family doctor. This made the student very uncomfortable in view of the chief complaint. Dr. Strauss then asked the student if it was difficult sleeping with one person and asked if the student would like to do more regarding sexual behavior. The student reported to Ms. Brady the Dr. Strauss had an erection and pushed against him. Further the student explained to Ms. Brady that Dr. Strauss appeared very flirty and would have come on to him if he would have sent any type of signal. This student also gave the name of another student to Ms. Brady.

The incident involving male student #3 (occurred on January 5, 1996. The student had gone to the center for treatment of an STD, a burning sensation while urinating. The student was called to the exam room by Dr. Strauss and once there the doctor instructed the student to remove his hat. Dr. Strauss the instructed the student to remove his shirt and then performed an upper abdominal exam. The student was then told by Dr. Strauss to put his shirt back on and to remove his pants. During the genital exam the student became erect and ejaculated. Dr. Strauss started talking to the student using "nuts" and "ass" in the conversation. Dr. Strauss then asked the student if he was "fucking" his girlfriend. The student "lost it," grabbed his medical records and cultures and threw them down the hallway, screaming, according to Ms. Brady. wanted to call the campus police but Dr. Strauss said not too. Dr. Strauss refused to explain to what happened in front of Ms. Brady. Ms. Brady referred the student to for treatment. Ms. Brady said that shortly after this incident Dr. Strauss was put on administrative leave by

Ms. Brady said that a Due Process Hearing was conducted by the Human Resource Department and the decision was made not to renew Dr. Strauss' contract. Prior to the hearing Ms. Brady said that received intimidating letters from Dr. Strauss' attorney. The letters also contained confidential medical information that was not authorized for release by Mr.

Investigator: K. R. Beck 63

Date Submitted: 12-4-96

RE: Richard H. Strauss, M.D.

Complaint No: 96-1534 A&B

Date: August 22, 1996

On October 4, 1996 I met with _____, to discuss the complaint. He said that Dr. Strauss is publisher of Sports Med magazine and was team physician for several male sports. In addition in 1994 Dr. Strauss started a mens clinic in the Student Health Center. In 1995 the center contracted with Dr. Strauss for 20% of his time.

_____ said that the first complaint he received was on January 3, 1995 from a student that had venereal warts. The student wanted a vinegear test, however, Dr. Strauss performed other tests. _____ said that the student also complained that Dr. Strauss examined his penis, scrotum and rectum under a surgical light and the student felt this was very invasive.

_____ received the next complaint on January 6, 1995 from a student with an enlarged breast. The student is homosexual and alleged that Dr. Strauss came on to him. _____ said that Dr. Strauss performed a genital exam on the student and asked the student if he was gay. Dr. Strauss then asked the student about sex with his partner and dating other men. The student said that during the exam Dr. Strauss had an erection and rubbed it against his leg. The student felt that Dr. Strauss would have gone out with him. _____ said that the student wanted three things; acknowledgement of any other complaints, his complaint brought forward if any other complaints are filed and a chaperone in the exam room and a release form signed by all patients. _____ said that this incident was mediated by _____ who is openly gay.

_____ said that last complaint he received was on January 5, 1996. _____ explained that while sitting in Ms. Brady's office he heard a student scream "this doctor's crazy." He wanted to call the police, however Dr. Strauss said no. _____ said that he questioned Dr. Strauss, in his office, who said that patient got an erection and ejaculated. Dr. Strauss described the student as a premature ejaculator, _____ said. _____ said that Dr. Strauss trembled and looked so guilty while explaining the incident. _____ said that Dr. Strauss changed his story everytime it was discussed. Further _____ said that Dr. Strauss admitted using "fuck ass and nuts" during the exam. _____ said that Dr. Strauss did not mention the erection or ejaculation in the patient record.

_____ said that Dr. Strauss was removed from the Department of Athletics _____, attended the hearing. _____ feels that there are many male athletes that have been abused by Dr. Strauss.

_____ said that Dr. Strauss sent _____ a letter mentioning _____ by name and his disease without a release from _____. Further _____ said that _____ received a letter from Dr. Strauss' attorney threatening punitive action if the complaint was not withdrawn.

Investigator: K. R. Beck ^(L)

Date Submitted: 12-4-96

RE: Richard H. Strauss, M.D.

Complaint No: 96-1534 A&B

Date: August 22, 1996

said that the university will back if sued by Dr. Strauss.

On October 8, 1996 I met with he
said that he has received complaints
second hand about Dr. Strauss doing improper exams on male patients.
said that , received complaints
from athletes and requested that Dr. Strauss be removed as team physician.
said that he sent a letter to Dr. Strauss removing him as
team physician of the fencing team. said that he received a
letter from an anonymous male swimmer complaining about Dr. Strauss; however
the student did not want to come forward. Additionally said
that Dr. Strauss had a locker in the student athletes locker room at
Larkins Hall and would shower with the student athletes. said
that he directed Dr. Strauss not to shower with the athletes and use a
locker in the faculty locker room. said that he terminated
Dr. Strauss from the Department of Athletics as a result of the Student
Health Center action. said that in 1991 he talked with
F
about the history of Dr. Strauss and recommended that I contact him for
further information.

On October 8, 1996 I met with She said that it has been rumored that if you
go to Dr. Strauss for an ankle problem you end up getting a complete
physical. provided a letter sent to Dr. Strauss advising of
the nonrenewal of his appointment to the Student Health Services.
Additionally recommended that I contact

On October 10, 1996 I met with to discuss the complaint.
said that he has been at OSU since 1984, first as a student then as a
trainer and has heard rumors about Dr. Strauss explained that if
an athlete had the flu and went to Dr. Strauss they would have to completely
disrope or drop their pants. said that he can recall several
students coming to him with complaints about Dr. Strauss and referred them
to or . Some of the other trainers have received
complaints about Dr. Strauss, said. Further explained
that Dr. Strauss was team physician for Ice Hockey and would go into the
locker room and take pictures of the athletes in various stages of undress.
aid that he will contact the trainers at Larkins Hall for the
names of athletes that complained about Dr. Strauss.

On October 16, 1996 I met with to discuss the complaint.
said that he was
said that he met Dr. Strauss in the late 1970's while Dr. Strauss was at
Harvard writing a book. said that he wrote a chapter on heat
stroke for the book. said that Dr. Strauss came to OSU and
wanted to work with athletes in minor sports so the both of them shares an
office at Larkins Hall for about 10 years. said that around

Investigator: K. R. Beck^{RS}

Date Submitted: 12-4-96

RE: Richard H. Strauss, M.D.

Complaint No: 96-1534A&B

Date: August 22, 1996

1979 the trainers were receiving complaints that Dr. Strauss was that too long (10 minutes) with the genital exam. said a genital exam should last 15-30 seconds. said that he counseled Dr. Strauss about the exams. said that Dr. Strauss also refused to have a trainer present during these exams. Next said that he had to counsel Dr. Strauss about showering with the student athletes. said that it was a joke among male athletes that you didn't want to be in the same room with Dick Strauss. said that he did not keep any record of the counseling sessions. Lastly said that he never received a complaint from a female athlete about Dr. Strauss.

On October 16, 1996 I met with to discuss the complaint. said that problems were first brought to her attention in 1983 by went to Dr. Strauss for severe blisters on his feet and Dr. Strauss wanted him to drop his pants. graduated in 1984 and is now and can be reached at said that she can remember athletes in 1984 telling her that Dr. Strauss was watching them take showers. aid that she has two that are willing to come forward and they are and 64.

On October 24, 1996 I met with at the OSU Student Union to discuss the complaint. said that he is a junior majoring in [REDACTED]. In 1994 as a freshman he tried out for the team and the first team meeting was held at Biggs Hall. During this meeting the sports physicals were given. said that the history and vitals were consistant with other physicals he received. Next he saw Dr. Strauss in the exam room. Dr. Strauss had remove his shirt and listened to his lungs and heart. said that this was consistant with the other physicals. explained that next Dr. Strauss told him to stand and remove his pants and underwear. Dr. Strauss checked for a hernia which was consistant with other exams. Next Dr. Strauss turned off the light in the exam room and sat down in front of indian style and asked "do you feel vulnerable," and began to examine his genitals with an odoscope. Next Dr. Strauss had feel a bump on his testicals and explained that it was for storing extrasperm. said the testical exam lasted about 10 minutes. Dr. Strauss then examined penis that lasted a long time. felt that he was fondled. said that he could see Dr. Strauss because there was ambient light coming through the curtains. feels the genital exam was inappropriate. Lastly said that Dr. Strauss used to shower with the athletes at Larkins Hall. Attached is a written statement and patient release form from

On October 25, 1996 letter was received from Dr. Strauss defending his removal as team physician of the [REDACTED] team.

On November 4, 1996 Investigator met with to get a written statement and a patient release form signed. was to busy at the time to give a statement, however, he did sign the release form.

Investigator: K. R. Beck^{RB}

Date Submitted: 12-4-96

RE: Richard H. Strauss, M.D.

Complaint No: 96-1534 A&B

Date: August 22, 1996

Attached is a memo dated November 27, 1996 from Investigator Barnett indicating that Dr. Strauss has opened a mens clinic in Grandview.

On December 3, 1996 I talked with _____ at Larkins Hall who advised that _____, was willing to give a statement about Dr. Strauuss. _____ and his home telephone number is _____. _____ said that he is working with another trainer and they are reviewing team rosters from prior years in an attempt to locate more athletes. _____ said that the medical records of athlete that are curently involved in a sport are kept in the training room in the building where the sport is located. The records of athletes that have graduated are kept in Biggs Hall for seven years. _____ said that over the years he has received numerous complaints from athletes and will try to recall the names. When he does he will call the Board with the information.

In conclusion, with the information provided it shows that Dr. Strauss has been performing inappropriate genital exams on male students for years. This has been brought to the attention of officals at the university and just recently action was taken.

This report is submitted for your review and disposition.

As long as names of athletes continue to be brought to my attention the investigation will continue.

Investigator: K. R. Beck^{MO}

Date Submitted: 12-4-96



Columbus, OH 43210-2200

Phone
FAX

ATHLETICS



Phone
FAX 614-292-0506



Judith L. Brady

Assistant Director for Administration
Student Health Services
1875 Millikin Road
Columbus, OH 43210-2200

Phone 614-292-0110
FAX 614-292-7042
E-mail brady.54@osu.edu



Columbus, Ohio 43221 • 614-



STATE MEDICAL BOARD OF OHIO
 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43265-2315

MD & DC SPECIALTY CODES CURRENTLY ON RECORD

IM INTERNAL MEDICINE

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1995 BIENNIAL PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

Richard Harry Strauss (SIGNATURE OF APPLICANT) 4/10/96 (DATE)

SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

IDENTIFICATION NUMBER 35-04-2299
 AMOUNT DUE \$250.00
 DATE DUE 05/01/96
 RICHARD HARRY STRAUSS, M.D.
 B 101 STARLING-LOVING HALL
 OHIO STATE UNIVERSITY HOSPITAL
 COLUMBUS OH 43210

STREET
 STREET
 CITY STATE ZIP CODE
 COUNTY

1:7696969696 21:

093504229901 00000025000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
 Street
 Street
 City State Zip Code
 County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

- 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES NO
- 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES NO
- 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES NO

AMOUNT \$250.00
 DATE 05/01/96
 ACCOUNT # 935042299

- 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES NO
- 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES NO
- 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES NO
- 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES NO
- 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES NO

Redacted SOCIAL SECURITY NUMBER

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
(614) 488-1094
June 25, 1996

*Randy -
Here's the info
from Dr. Strauss.
Marcia*

Ms. Marcia Barnett
State Medical Board of Ohio
77 South High St.
17th Floor
Columbus, OH 43266-0315

Dear Ms. Barnett:

Thank you for interviewing me last week about my complaint against [redacted]. At that time, I gave you copies of my two letters to [redacted] dated June 5, 1996. In one of those letters, I referred to Cases 1 and 2, both from January, 1995. I believe that the correct spelling of the patient in Case 1 is [redacted]. His first name may be [redacted]. If you decide to retrieve information about that patient from the O.S.U. Student Health Services, there should be no problem in correctly identifying him. Ask Judy Brady, Assistant Director of the Student Health Services. She handled that matter.

Enclosed is a copy of my Staff Performance Evaluation from the Student Health Services. My Overall Evaluation was "Excellent". It was signed and dated by [redacted] on July 1, 1995. Please note: that was six months after the resolution of Cases 1 and 2, and confirms that their resolution was in my favor.

Sincerely,

Richard H. Strauss
Richard H. Strauss, M.D.
Professor of Public Health
The Ohio State University

STATE MEDICAL BOARD
OF OHIO
96 JUN 27 01 14:45

OSU Administrative & Professional Staff Performance Evaluation

Name Richard H. Strauss Position Title PHYS H SER

Department Student Health Services Dept. No. 310900

Rating Type: Probationary Probationary Period Ending Date _____
(check appropriate box(es)) Initial
 Promotional
 Annual Anniversary Date _____

For each rating element below, place a check mark in the box which, in your judgment, most clearly describes this staff member's performance. The performance level definitions are: **EXCEPTIONAL**—Staff member's performance continuously exceeds standards; **EXCELLENT**—Staff member's performance always meets and frequently exceeds standards; **GOOD**—Staff member's performance meets standards; **MARGINAL**—Staff member's performance is often below minimum standards; improvement in many areas is essential; **UNSATISFACTORY**—Staff member's performance is frequently/continuously below minimum standards. Use the space marked **EXPLANATION** to clarify each rating. Before completing the performance evaluation form see additional instructions on reverse side.

A. JOB KNOWLEDGE—Consider the staff member's application of administrative, professional, technical, managerial or other specialized knowledge, skills and abilities to the performance of specific job duties and responsibilities. Evaluate demonstrated knowledge of a particular field, learning potential and versatility. Appraise the staff member's desire to increase his/her job knowledge through formal or informal study, seminars, readings and other professional endeavors both on and off the job.

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

B. ACHIEVEMENTS/ACCOMPLISHMENTS—Consider the level of achievement by the staff member and the degree of excellence of work accomplished in relation to known standards/expectations. Evaluate the individual's ability to yield effective results in spite of work load/responsibility variations or demands. Appraise the staff member's contribution to the department and/or administrative area in terms of specific projects, goals, objectives and/or performance targets attained during the rating period. Assess the individual's overall productivity.

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

C. COOPERATION WITH OTHERS/COMMUNICATION SKILLS—Consider the staff member's effectiveness in maintaining harmonious working relationships with University staff, students and the public. Evaluate the individual's effectiveness in expressing ideas, facts and data through speech, writing and graphics (where appropriate). Appraise the person's response to new procedures and instructions and alertness to lines of communication, both upward and downward. Evaluate how easily the staff member communicates and the extent to which he/she determines what information is important and what is not appropriate for communication to others. Assess his/her ability to accept and evaluate suggestions from others and to resolve disagreements in a professional manner.

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

D. PROBLEM-SOLVING/DECISION-MAKING—Evaluate the staff member's ability to identify problems and apply logic and reason to the resolution of same. Consider the extent to which the individual is able to make rational decisions within discretionary limits. Appraise the individual on her/his ability to think in terms of and understand the work being performed (e.g., the ability to select the proper method, technique, or procedure necessary to achieve a desired result).

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

E. PLANNING—Evaluate the staff member's ability to set specific goals, objectives and timetables in order to accomplish various tasks and complete assigned projects within required deadlines. Appraise the individual on her/his ability to organize, allocate and schedule human, financial, material and time resources effectively.

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

F. CREATIVITY/ORIGINALITY—Evaluate the ability of the individual to utilize innovative and/or cognitive skills to develop, apply and/or modify ideas, concepts, methods, systems, policies, procedures, techniques, products, forms, etc. as required within the context of the staff member's job.

RATING: Exceptional Excellent Good Marginal Unsatisfactory
EXPLANATION:

Name RICHARD STRAUSS Department STUDENT HEALTH SERVICES

G. SUPERVISION/LEADERSHIP (complete only for staff with supervisory responsibilities)—Consider the individual's ability to train, supervise, motivate and obtain desired results from subordinates. Evaluate overall leadership capability. Appraise the staff member in terms of the extent to which his/her work unit accomplishes stated goals and objectives.

RATING: Exceptional Excellent Good Marginal Unsatisfactory

EXPLANATION:

OVERALL EVALUATION—Consistent with the individual ratings assigned above, evaluate the overall performance of the staff member. Although this evaluation should represent a composite of the above ratings, emphasis should be placed on those of particular importance and/or value to this individual's job.

- EXCEPTIONAL:** Staff member's performance continuously exceeds job requirements; performance in all areas is superior; a truly exceptional staff member.
- EXCELLENT:** Staff member's performance continuously meets job requirements and often exceeds them; individual has many commendable areas of performance.
- GOOD:** Staff member meets job requirements; improvement is desirable in some areas.
- MARGINAL:** Staff member's performance below minimum job requirements; improvement in many areas is essential.
- UNSATISFACTORY:** Staff member's performance continuously below minimum job standards; work totally unsatisfactory.

EXPLANATION:

STAFF RECOGNITION—List the staff member's performance assets. Note those areas in which the individual excelled during the rating period. Include specific tasks, projects, etc. accomplished and/or performance targets, goals or objectives achieved which were of particular importance to the overall mission of the department and/or administrative area.

A guiding force in program development, expansion. Always keeps the patient's needs first.

STAFF GROWTH AND DEVELOPMENT—List possible actions which the staff member should take to increase job-effectiveness within the context of his/her current position only. (Your assessment may, where applicable, include a discussion of the staff member's overall improvement or lack thereof since the previous evaluation.) You are encouraged to determine these actions in conjunction with the affected individual. Include specific tasks, goals, objectives, performance targets, etc. which should be accomplished during the next rating period. Consider self-development activities; areas where the supervisor and staff member can work together to resolve problems; development needs which may, where applicable, be met by training programs. Be as specific as possible. Attach additional pages if necessary.

I look forward to many new and creative steps in the SHS Men's Clinic

STAFF COMMENTS (to be completed by staff member)—Include specific activities which you feel should be accomplished to increase your job-effectiveness during the next rating period. You may also comment on any aspect of the evaluation process itself which you believe to be important. Attach additional pages if necessary.

I enjoy working here. The physicians and staff are always helpful. Drs. Miller and Grace are helpful consultants

My supervisor has explained this evaluation to me Yes No.

Signatures

Staff member R. H. Strauss Title Physician Date 6/27/95
 Rater _____ Title _____ Date 6-27-95
 Dept/Vice President _____ Date 7-1-95

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
June 5, 1996

[REDACTED]

The Ohio State University
33 West Eleventh Avenue
Suite 115
Columbus, OH 43210

Dear Mr. [REDACTED]:

As you know, one of the patient's who visited me in the Men's Clinic at the Student Health Services on January 5, 1996, filed a complaint. In her letter to me dated March 13, 1996, states that the patient complained

that I:

- 1) Had inappropriately touched him.
- 2) Unnecessarily prolonged the examination.
- 3) Used inappropriate language during the examination.

I deny all of these allegations.

Following is my account of what transpired. Included in parentheses are explanatory notes that give additional information.

First, I would like to give you some background information. In October, 1993, I was the founding director of the Men's Clinic, which became one of the most popular clinics at the Student Health Services. This clinic is patterned after a gynecology clinic, except that it is for men. The Men's Clinic treats mostly dermatology and urology problems of the male genitourinary systems and perianal area. Men with psycho-sexual problems also are seen at the clinic. Sexually transmitted diseases account for more than half of the patient visits, with urological problems such as testicular pain or scrotal masses accounting for most of the rest of the visits.

I would like to point out my training and experience in the management of sexually transmitted diseases. One of the best known and most widely respected centers in the world for research and training in sexually transmitted diseases is located at the University of Washington in Seattle. The director is King Holmes, M.D. He is also the editor of the textbook *Sexually Transmitted Diseases*, which is the "Bible" on this topic and is found on the reserve shelf of almost every medical library in the United States.

From 1968 through 1970, I was a Fellow (a post-M.D. training

position) at the University of Washington. During that period I worked part-time at a sexually transmitted disease clinic staffed by faculty, residents, and fellows from the University of Washington School of Medicine. I was trained in the management of sexually transmitted diseases using the methods described by Dr. Holmes in his textbook.

At this point, please look at Attachment 1, entitled "Anatomy and Physical Examination of the Male Genital Tract". It is part of Dr. Holmes book and was written by two professors at the University of Washington. It describes in detail the methods that I was trained in and have followed, rigorously, for the past 28 years when performing examinations for sexually transmitted diseases (STD's) in males. Portions that are particularly relevant to the patient under discussion are marked by pen and will be referred to during the following narrative. The examination is designed to be thorough because a patient who becomes aware of one sexually transmitted disease often has one or more additional diseases of which he is not aware.

I have treated thousands of cases of sexually transmitted diseases and male genitourinary problems over the past 30 years: as a Medical Officer in the U.S. Navy, at several universities, and at The Ohio State University among varsity athletes and at the Student Health Services during the past 17 years.

There was never a complaint against me about such treatment until January, 1995, in the Men's Clinic. Why did this suddenly occur? I suspect the answer is that previous patients knew me before their visit or had heard of me through the grapevine as the "go to" doctor for men's problems. In other words, the patient's chose to see me, rather than other physicians available to them, because they trusted me ahead of time and thought I would do the best job.

The Men's Clinic is different from the Athletic Department for two reasons:

1) It is part of the Student Health Services. Unfortunately, students tend to view the Student Health Services like dormitory food: not very good and something to complain about.

2) The patient's do not know me ahead of time and have no information about my level of expertise. I suspect that, sometimes, when a patient walks into my office, he thinks that he has stumbled onto a white-haired doctor who is retired and can't get a real job. And some students probably doubt the ability of a doctor who looks to be about sixty to relate to their sexual problems.

One of the most experienced doctors in the Medical Clinic of the Student Health Services put it to me succinctly: "I'm glad you are taking care of the STD problems. I didn't like doing it. The patient's come in, they hate having the disease, they are embarrassed to see the doctor, they don't like the exam, and the cultures hurt. They just want to get out of here."

When I see a patient in the Men's Clinic, this is the mindset that I must overcome in the first two minutes of the visit or

the patient is too tense, nervous, and suspicious for the examination to proceed with any degree of confidence and trust.

I have one of the lowest complaint rates in the entire Student Health Services and, by far, the lowest of the doctors working in the Men's Clinic. (See Attachment 2.) This is the case even though I had 3,000 patient-visits in 27 months, all of them requiring genital exams. This is most sensitive, high risk area for a physician to treat.

In a study of patient satisfaction conducted by [REDACTED] who was [REDACTED] of the Student Health Services before leaving in [REDACTED] I was rated as the most popular physician in the Student Health Services.

Next, I would like to give a narrative of the visit of "the patient" under discussion to me on January 5, 1996, and the events that followed.

I picked up the patient's medical record from the box on my office door and called him in at approximately the time of his appointment. I introduced myself as Dr. Strauss and asked him to take a seat in the chair adjacent to my desk. He seemed a little nervous, but many patients are uncomfortable at first, and part of the challenge of the Men's Clinic is to make them comfortable as quickly as possible, which I try to do with some general conversation.

I asked the patient what his (academic) major was. He told me, but I have forgotten the answer. He was speaking mainly toward the floor and was wearing a baseball cap with the bill forward, so I could not see his face. I asked the patient if he would mind taking off his cap. I explained that this was not a fashion statement but that I could communicate better with patients when I could see their faces and eyes. (I always ask patients to take off their caps for this reason. Also, I can then see the skin of their forehead and their hair, which is helpful for diagnosing skin problems that effect not only the genitals but also other part of the body: for example, atopic dermatitis, psoriasis, or alopecia areata.) The patient removed his cap and set it on the floor next to his chair.

I asked the patient where he was from. He said he was from [REDACTED] but he and his family had moved to the [REDACTED] eight months earlier from [REDACTED] where his father had worked in business for a while. I remarked that he had picked up an [REDACTED] accent rather quickly, to which he agreed.

Then I looked at the form which we have all new patients fill out (see Attachment 3). Since this is one of the forms that the patient subsequently destroyed, I will describe the pertinent information as I remember it.

Question: "What is the problem that brings you in today?"
 Answer: "UTI". This is an abbreviation for urinary tract infection, which is close to one of the two final diagnoses, but is not precisely correct.

I think the answers to the remaining questions on page 1 were "no" but I cannot remember for sure.

On page 2, we are very specific about getting permission to do the physical examination so nothing takes the patient by surprise and so the patient can chose to exclude any part of the examination that he feels uncomfortable about. Following, I quote the permission form:

"The physical examination that we perform in the Men's Clinic is tailored to the specific problem that you tell us about. It generally includes the following parts of the body. However, if you prefer that a specific area not be examined, please cross it out of the following list:

1) Skin of upper body. This is done because skin problems below the waist sometimes are related to skin problems above the waist. Lymph nodes (glands) of the neck and under the arms are felt at the same time.

2) Skin of the public area and genitals, including the penis and scrotum. Contagious diseases such as warts are sometimes visible.

3) Feeling both testicles for lumps, for example, cancer."

I remember very clearly that the patient did not cross out any of the above choices. If he had, I would not have done that part of the examination.

Another important part of page 2 is as follows:

"Sometimes a technician or medical student works with us. Do you prefer than such a person be (circle one):

Present
Not Present
Don't Care"

I clearly remember that the patient circled "Not Present". He signed and dated the form.

Next, I proceeded with the history. Please see Attachment 4. This a copy of my medical report about the patient which was produced using my standard format on my computer in the Men's Clinic. It was produced after _____ prevented me from entering my report in the patient's official medical record but before I left the Men's Clinic on January 5, 1996. I took this medical report home with me and have not altered it in any way since it was produced. Following is an expanded narrative, based on this medical report.

I asked the patient what the problem was that brought him in. He said that he had burning inside his penis when he urinated during the past three days.

I asked if he had noticed any drip or discharge from his penis between urinations. He said he had not noticed any.

The patient said he had returned a few days ago from visiting his girlfriend in _____. They had intercourse, not using a condom. His girlfriend had been treated for a "bladder infection" two or three weeks ago. He did not know with what medication.

The patient said he had no other symptoms or abnormal

findings.

Next, I began the physical examination. I always use the same routine for physical examinations for sexually transmitted diseases. I will describe what I did in this case and will refer you to marked sections in Attachment 1 (the book by Dr. Holmes) for more detail from a standard authoritative source.

I asked the patient to stand and take off his shirt. (See Attachment 1a.) As he did so, I put on latex gloves, which I wear for all parts of the examination. The patient was a slender but normally developed 18 year old caucasian male. I palpated (felt) the patient's cervical (neck) lymph nodes, looked at the skin of his face, palpated the right and left axillary (armpit) lymph nodes, and looked at the skin of his chest. All of this was normal. I palpated both areolae (nipples) for gynecomastia (breast tissue common in puberty and post-puberty, in users of anabolic steroids, and in some liver diseases; also associated with testicular tumors). There was no gynecomastia.

I asked the patient to raise both arms. Both axillae appeared normal. There were no skin tags or molluscum contagiosum which are sometimes associated with the same diseases in the pubic region. There was no dermatitis, which is sometimes seen in association with atopic dermatitis of the penis.

I asked the patient to put his arms down and turn around. There was no discoloration on his back to indicate tinea versicolor, a fungal infection which patients sometimes wish to have treated. Then I told the patient to put his shirt back on and he did so.

I told the patient that everything was normal, so far.

I asked the patient to move to stand in front of the examining table. I sat in front of him in my chair and said, "Pants down, please." The patient did so.

He said, "Underwear, too?"

I said, "Yes." (Most patients lower their pants and underwear at the same time. This two-step procedure suggested that the patient was shy about exposing his genitals, even though he expected to do so. I would estimate that about 3% of my patients ask "underwear, too?")

The patient lowered his underwear.

I said, "Tell me if I cause you any discomfort."

The patient said, "OK".

I palpated the inguinal (groin) lymph nodes on both sides. (See Attachment 1b.) They were normal. There was no bulging or history to suggest an inguinal hernia so I did not palpate for a hernia or ask the patient to cough.

I palpated both testes. (See Attachment 1c.) I said, "Does that hurt?"

The patient said, "No."

Both testes were descended, normal in size and consistency, and not tender. (The highest incidence of testicular cancer is in college-age males. Thus, the testicular examination is particularly important.) The right and left epididymis and

spermatic cords were normal and not tender. (See Attachment ld. It is not unusual for infections of the urogenital tract to involve the epididymis.)

Next, I asked the patient to lie down on the examining table, against which he was leaning. He lay down on his back, as asked.

I have a large "operating room" light above the table. I turned it on and adjusted it to illuminate the patient's pubic and genital region (see Attachment le). I wear glasses for all parts of the examination. In addition, at this point I always put on 8X binocular magnification lenses in preparation for examination of the pubic area and genital skin (see Attachment le). This enables me to see very small warts, pediculosis pubis (crab lice), eggs attached to hair shafts, etc. I can push the 8X lenses up, out of the way, to get a broader view or to look at the patient's face when conversing.

As I was about to look at the patient's pubic area I noted the pulsations of his abdominal aorta. Because the patient was slender, they were easy to see. His pulse rate seemed higher than normal (I did not measure it) which indicated to me he was still nervous. This is unusual since, by this time, most patients are quite relaxed. I believe they relax because they are comfortable with me, even though the examination is often a new and embarrassing experience for them.

I looked at the patient's face and asked him if he was comfortable. He looked down, toward me, said, "Yes", and looked back at the ceiling. I have a small sign on the ceiling, above the patient, that says, "Everybody Sweats". Many patients laugh when they notice the sign because, by that time, they are often getting over a cold sweat from fear and they realize it. Humor helps break the ice (most of the time). This patient did not laugh.

I put my 8X magnifiers back in front of my glasses and examined the pubic area. I found no skin abnormalities and no parasites.

I examined the skin of the scrotum and the right and left crurae (see Attachment lh). I saw no abnormalities, no tinea cruris which is common in this population.

I examined the skin of the penis, moving it so I could visualize the dorsal, ventral, and lateral sides. I saw no warts, no abnormalities.

The patient was uncircumcised. I retracted the foreskin (see Attachment lf). The penis under the foreskin was unusually wet and had a mildly "foul odor" (this is a medical term, not an insult). These were signs of a urethral discharge being present, even though the patient had not noticed it. (Uncircumcised males frequently do not notice a urethral discharge because it gets trapped under the foreskin.) The urethral discharge was consistent with the patient's symptom of burning with urination.

As I held the foreskin retracted and examined the glans and inner surface of the foreskin (see Attachment lf), the patient started to become erect. This is a reflex that happens

occasionally (see Attachment 5). I said to the patient, "You are starting to get an erection. No problem." (I always talk to the patient about this reflex. See Attachment 5). I put his penis down (as I always do when this occurs). Immediately, about 1 ml. of opalescent white fluid (semen) pooled on the patient's abdomen at the meatus (opening) of his penis.

I said, "Uh--you ejaculated." I pushed up my 8X lens and looked at the patient's face. "Are you OK?", I asked.

The patient raised his head and looked down at his abdomen. "Yeah," he said, as he put his head back on the examining table and looked at the ceiling again. He did not seem startled or upset, although I was surprised by this highly unusual event. (This is a type of premature ejaculation known as "acute onset premature ejaculation with erectional insufficiency". See Attachment 6.)

"Well; that's what gloves are for," I said, trying to reassure the patient. I removed the secretions with Kleenex, disposing of it in the hazardous waste container. Then I pulled off my gloves and disposed of them.

I turned to the patient. "Do you want to go ahead with the urethral cultures?" I asked.

"Will it hurt?" he asked.

"A little," I said. I wanted the patient to know he was in control.

"Will you stop if it hurts?" he asked.

"Of course," I said.

"OK," said the patient.

I put on a new pair of latex gloves, got a sterile cotton swab, picked up the end of the patient's penis with my left hand and retracted the foreskin slightly so I could reach the meatus without contamination from the foreskin. I inserted the swab about one centimeter into the urethra to obtain culture material and streaked the TM plate (for gonorrhea) and then covered it. "Did that hurt?" I asked.

"Not very much," the patient replied.

"Shall I go ahead with the other culture?" I asked.

"Yes," said the patient.

I performed a culture for chlamydia using the same technique. However, the container for the chlamydia DNA probe is much stronger. It is designed to be transported, even by the U.S. Mail, and is almost bomb-proof. The tube is made of strong plastic and it has a strong, plastic, screw-on top, which I screwed on firmly. I turned to the patient and said, "You can get dressed now."

The patient got dressed and sat in the chair by my desk.

I said, "From your symptoms and the small amount of urethral discharge, my guess is that you have nongonococcal urethritis--probably from chlamydia. We won't know for sure until we get the cultures back."

The patient seemed comfortable. "Will I get the same kind of medicine my girlfriend got?" he asked.

"Do you know what the drug was that she got?" I asked.

"Some pills," he said.

"I don't know, then," I said. "I usually treat this problem with Doxycycline, one pill twice a day for a week. You can come back in one week to get the results of the cultures. Is that OK?"

"Yes," he said.

"I'll give you a prescription," I said. I hesitated. "One of the problems we treat here is premature ejaculation," I said. "What we had here was an example of premature ejaculation." The patient looked at the floor. "Is that a problem you've had with your girlfriend?" I asked.

"No," the patient said. He looked uncomfortable talking about it so I decided to drop the subject.

Next I said, "I guess we're finished." I reached for the computer on my desk and said, "I'll let you read your medical write-up."

The patient looked startled and became agitated for the first time during his visit. "Fuck you, then!" he shouted as he abruptly stood up, yanked the door open, and strode from the room. The phrase stuck in my mind because the patient shouted the epithet in a _____ accent, rather than the _____ accent that he had been using.

I concluded that the patient was upset--upset suddenly and specifically at what he was afraid I was about to write, or had written, in his medical record. My guess was that he did not want me to write that he had ejaculated in my office. I suppose most guys would be embarrassed about that.

As the patient passed the receptionist and left the waiting room, he shouted something which neither the receptionist nor I could understand.

A few minutes later,

_____ entered my office and said that my "last patient" wanted to see his medical record. I told that I would meet him and the patient immediately in _____

_____ left and I picked up the patient's records and his two urethral cultures from my desk and walked across the waiting room toward the hallway to _____. I saw the patient at that time, confronting and verbally abusing the _____, _____ and demanding that she remove all records of his visit from the computer system in front of her. She denied his request.

At that moment, the patient saw me and shouted, "I want my records. I want the paper I signed". I said, "Come on and we'll talk," as I walked toward _____. The patient ran after me and wrenched the medical records from my hands, scattering the cultures on the hallway floor. He then rapidly walked back into the reception room, approached _____ again, and demanded that she remove all information about him from the computer system. He tore up medical records and threw various items at _____. The patient then left the Men's Clinic.

Minutes later, _____ initial reaction was, "We should

call the campus police."

A few minutes after confronting [redacted] for the second time, the patient visited [redacted]. [redacted] told me that he gave the patient an antibiotic for a sexually transmitted disease based on the patient's history. [redacted] said that he did not do a physical examination or take any cultures.

I talked with [redacted]. He said that the patient had just talked to him and had accused me of inappropriately touching him, which I denied. I offered my explanation for the patient's behavior: specifically, that the patient would go to any extreme to prevent me from recording his premature ejaculation in the official medical record.

[redacted] said that the patient was from "a well-connected and influential family from [redacted]". He said that the patient's mother had called and that she was quite "reasonable". She only insisted that "Dr. Strauss not be allowed to write anything in [the patient's] record" and that [redacted] "get rid of Dr. Strauss."

My write-up of every initial patient-visit is printed in detail in the patient's record because I produce it on my computer in the presence of the patient. [redacted] instructed me that I was not to write my usual report about the patient. I objected. I said that I could not even imagine what to write if it wasn't my usual, printed report. [redacted] said that he would ask Judy Brady to come in and they would determine what I should write in the record.

Judy Brady joined us in [redacted]. She was carrying a plastic culture tube. She said that the patient's culture in the petri dish (gonorrhea) was destroyed because it lay open on the hallway floor, but this culture (chlamydia DNA probe) was still good (viable), because the plastic tube was undamaged and the top was still on tight. "What should I do with it?" Ms. Brady asked. [redacted] ordered her to destroy the viable chlamydia culture.

Ms. Brady said that the patient had talked to her. She sat down.

"What did he say?" I asked. Ms. Brady hesitated. "Could we be brutally frank?" I asked. Ms. Brady looked at [redacted] who nodded.

Ms. Brady quoted the patient as follows: "Dr. Strauss said I had an erection. I don't know if I did or not. Dr. Strauss said I ejaculated. I don't know if I did or not."

"Anything else?" I asked.

"He said you used unprofessional language," she said.

"What, specifically?" I asked.

"He said you used 'fuck, nuts, and ass'," Ms. Brady responded, embarrassed.

"I did not use any of those words," I replied.

[redacted] and Ms. Brady then discussed what I should write in the patient's record--specifically, the words that would satisfy the patient's mother. I objected, since I knew I was required to write a complete record in the patient's chart.

replied that if I wanted to write up my report, he would "put it in a secret place--where it would not be found if there were an investigation." I declined.

Then said that I could write whatever I wanted and keep it at home. At that point, I hand-wrote and signed a sentence in the patient's record, as dictated by : that the patient had "refused treatment."

Before I left the Men's Clinic the same day, I wrote an accurate record of the visit and took the record home (see Attachment 4).

On the next working day, Monday, January 8, called me into his office. He said that the patient had chosen to pursue a complaint against me for "inappropriate touching" and that he, had taken four hand-written pages of notes about the patient's complaint.

"What, specifically, does 'inappropriate touching' mean?" I asked.

"I told you," said . "Inappropriate touching."

"Give me an example," I said.

"I already said it: inappropriate touching," he said.

"I already denied inappropriate touching," I said.

said that the patient also complained that I made him take off his baseball cap and that I had a sign on the ceiling.

said that, effective immediately, I was under clinical suspension and that I should remove my personal belongings from my office and leave.

It was a short meeting.

In conclusion, I would like to respond to each of the complaints cited by at the beginning of this document.

1) At no time did I inappropriately touch the patient. I did a very thorough examination in accordance with the highest recognized standards. The examination was specifically designed for the patient's stated problem--a sexually transmitted disease. I have performed this same examination on thousands of patients for thirty years, with one of the lowest complaint rates of any physician doing this type of examination.

2) I did not prolong the examination. In fact, I shortened it. The part I left out is described in Attachment 1g, which I quote: "The urethra [the tube inside the penis] should be 'milked' or stripped, beginning... behind the scrotum in the midline and proceeding to the meatus [at the end of the penis]. This is necessary for evaluation for urethritis [which the patient had] and may result in an expression of discharge at the meatus."

I normally do this after I examine the skin of the penis, including the foreskin, when present. But since the patient had just ejaculated, I figured it was useless.

Incidentally, I have stripped the urethra of thousands of males and none of them ejaculated.

3) I did not use inappropriate language during the examination. The only inappropriate word during the visit was "fuck", which the patient said. "Fuck you, then!" he said as he stormed out.

It is unfortunate that the patient ejaculated in my office, but that's his problem, not mine. It is clear from the patient's actions--tearing up medical records, destroying cultures, demanding that _____ remove his records from the computer system, assaulting her and me in the process--that he would do everything possible to prevent me from making an accurate medical report. He then invented his complaints--all of them--as a smoke screen for his actions and to discredit me and anything I might put in his medical report.

Within minutes the patient called his mother and got her to put pressure on University officials on behalf of his "influential and well-connected family from _____. This would seem to imply that the family has influence with the Chairman of the Board of Trustees of The Ohio State University. His mother certainly got the attention of _____ who violated 1) state law; 2) regulations of the Ohio State Medical Board; and 3) regulations of the University, by preventing me from entering an accurate report of my medical findings in the patient's record. After that, _____ was stuck--part of the grand cover-up.

I believe that my five-month clinical suspension resulted from the over-reaction of one patient and the political influence of his family. I request that I be reinstated immediately and that my contracts with the Student Health Services and the Athletic Department be renewed.

Please note: I do not intend to allow my career to be destroyed by a young man attempting to use political influence to cover up an embarrassing medical finding. _____ is part of this political cover-up and should be fired. My official complaint against _____ should proceed in a thorough manner to its conclusion. As far as I'm concerned, the battle has just begun.

Sincerely,



Richard H. Strauss, M.D.
Professor of Public Health

Attachment



SEXUALLY
TRANSMITTED
DISEASES

SECOND EDITION

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SEXUALLY TRANSMITTED DISEASES

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Chapter 10

Anatomy and physical examination of the male genital tract

Daniel O. Graney
John N. Krieger

INTRODUCTION

Any area of the body may be involved in sexually transmitted disease syndromes or in the differential diagnosis of these conditions. Clearly there is no single, optimal method for conducting the history and physical examination. The critical areas of interest are determined by the history, other physical findings, and conditions considered in the differential diagnosis. There are as many correct ways of eliciting historical data and physical findings as there are clinicians. Similarly, there are many critical anatomical points that may be important in some contexts yet irrelevant in others. Thus, this chapter reflects our bias and represents an attempt to succinctly present one approach to "the routine examination." Pertinent genitourinary tract anatomy will be presented in the context of this examination. This approach is selective in the extreme, but it is based on our own clinical experience in developing an efficient method for evaluating a large number of patients in a timely manner.

Most often, the standard examination of a patient in our clinic proceeds according to an orderly sequence. The pertinent portions of the examination usually follow the outline in Table 10-1. Proceeding in this fashion has two advantages. First, there is an orderly sequence to the examination that limits the oppor-

tunity for errors of omission in a busy clinical situation. Second, there is a minimal need for the patient to move. Ordinarily, we initiate the examination by having the patient sit on the examining table. If necessary, head and neck examination and percussion and auscultation of the chest may be done in this position. Next, the patient is asked to lie supine. Cardiovascular examination may be conducted in this position, if indicated, and attention is directed to the abdominal examination. The patient is then asked to stand for examination of the groin and genitalia. Finally, the patient is asked to turn and bend over, placing his elbows on the examining table, for the rectal and prostate examination. In sum, there is minimal need for the patient to move from position to position if the examination is done in this order.

The remainder of this chapter is organized to follow this suggested pattern of evaluation. The relevant considerations in routine examination of the male are presented for each section of the physical examination, and critical anatomical principles are considered for that area. Throughout, we emphasize a practical approach and minimize use of Latin terms. This means that we present the anatomy according to our own opinions, recognizing that some of these opinions are controversial and that other anatomists and/or clinicians may hold alternative, equally valid, viewpoints.

There are two major differences in anatomy and examination between male and female patients. First, in the male we are talking about genitourinary tract examination. In the female there is a urinary tract and a separate genital tract. These two functions are combined in the male lower genitourinary tract, in which the urethra serves as a common conduit for the excretory functions of the urinary tract and for the reproductive functions of delivery of semen. The second major difference is that the critical reproductive organs in the male are all easily palpable. In contrast, the reproductive organs in the female are located in the pelvis and therefore may be examined less readily than the comparable structures in the male. The clinical implication is that examination of the male lower urinary tract and the entire male genital tract is readily accomplished and is straightforward in most patients.

Table 10-1. Routine STD Examination of the Male

General appearance
Skin
Abdominal examination
Groin
Hernia
Adenopathy
Genitalia
Penis
Prepuce
Urethral meatus
Shait
Scrotum
Testis
Vas
Epididymis
Rectal examination
Tone
Fissure, hemorrhoids, or mass lesions
Prostate examination
Laboratory studies
Stool guaiac
Urethral smear
Urinalysis
Other

1a

EXAMINATION OF THE ABDOMEN AND GROIN

ABDOMEN

Complete details of the abdominal examination are beyond the scope of this chapter. However, brief mention is necessary of the pelvic organs, specifically the urinary bladder. This may be distended in patients with bladder outflow obstruction caused by an enlarged prostate or urethral stricture, and occasionally in patients with neurological dysfunction, as may occur with herpetic infections. The normal bladder is not palpable or percussible when it is empty or nearly empty because of its location in the pelvis. As the volume increases to approximately 125 to 150 ml, the dome of the bladder rises out of the pelvis into the lower abdomen and may project above the symphysis pubis. As it continues to fill, the bladder rises progressively toward the umbilicus. When the bladder contains 400 ml or more, it may be identifiable by observation as a bulge in the lower abdomen. Percussion over a distended bladder may cause the patient to experience a desire to void and may result in a change of the normal resonance of the lower abdomen on percussion to a dull note. The distended bladder may be palpated as a firm, round, and tender mass in the lower abdomen.

GROIN

The groin, or inguinal region, should be examined for the presence of adenopathy while the patient is lying supine on the examining table. The patient is then asked to stand and the inguinal area is again examined for the presence of hernia by direct palpation of the area and again by insertion of the index finger through the neck of the scrotum following the spermatic cord. Both examinations are done with the patient standing quietly and again while he is straining.

GENITALIA

PENIS

Examination

It is critical that the clinic staff instruct patients to refrain from voiding, if at all possible, prior to examination because signs of urethritis may not be apparent if the patient has recently voided. In fact, in symptomatic patients who do not have objective evidence of urethritis on examination or on the urethral smear, it is our practice to repeat the examination prior to the first urination of the day. Initially, attention is directed to examination of the skin. Use of a good light source and a hand lens is strongly recommended. In patients undergoing evaluation for condylomata or sexual contacts of patients with condylomata, including women with dysplasia or carcinoma of the cervix, an acid "wash" is applied after the initial evaluation. This is done by soaking gauze pads in 3 to 5% acetic acid. The gauze is then applied to the skin of the scrotum and penis and left in place for 5 min prior to repeating the examination. This examination should be carried out with use of magnification looking for "flat warts."

Attention is then directed to examination of the penis. In uncircumcised patients, the foreskin should be retracted to rule out phimosis with an obstructing small opening. This maneuver may reveal balanitis, condylomata, and, occasionally, tumor, as the cause of a foul discharge. The glans and inner surface of the foreskin should be inspected to rule out presence of ulcers, vesicles, or warts. The location of the meatus is determined and the urethra is examined for presence of spontaneous discharge. If the location of the urethral meatus is abnormal, it can usually be found by following the midline along the undersurface of the penis. This is the most common location for an abnormal orifice and is termed *hypospadias*. Hypospadias is associated with a prepuce that does not completely encircle the glans but is incomplete on the lower surface. This is commonly termed a "hooded prepuce." Patients with more severe degrees of hypospadias, in which the urethral opening is located at the base of the penis or on the perineum, often have bifid, or split, scrotums. Rarely, the location of the urethral meatus may be on the upper surface of the phallus, a condition termed *epispadias*. In either hypospadias or epispadias, there is apt to be chordee, or an abnormal curvature of the phallus. Partial or complete duplication of the urethra may be noted. Commonly, patients with urethral duplications who present with urethritis have involvement of the accessory urethral meatus. The urethral meatus is examined by pinching the glans between the thumb and the forefinger at the 6 and 12 o'clock positions. This is important to exclude presence of meatal stenosis or intraurethral lesions, such as condylomata.

The shaft of the penis is palpated, looking for firm fibrosis plaques (characteristic of Peyronie's disease) and the urethra is

palpated for evidence of induration. Induration is often secondary to infection, stricture (or scarring), or, rarely, tumor, abscess, or foreign body inserted by the patient. At this point, the urethra should be "milked" or stripped, beginning at the bulbous urethra (located at the perineal body, behind the scrotum in the midline) and proceeding to the meatus. This is necessary for evaluation for urethritis and may result in an expression of discharge at the meatus.

Anatomy

Major Divisions. There are two parts of the penis, the base, which is attached to the pubis, and the pendular portion. Underlying the penile skin there are three cavernous erectile bodies, the paired corpora cavernosa that are primarily concerned with erection, and the corpus spongiosum which contains the urethra. These erectile bodies are separate structures at the base of the penis but become bound by fascia along the shaft of the penis (Fig. 10-1). The corpora cavernosa are cylindrical bodies in the shaft region but taper markedly at the base where they attach to the pubic ramus and perineal membrane. The corpus spongiosum has three parts: beginning at the perineum these are the bulb of the penis, the spongy portion, and the glans at the tip of the penis.

The base and proximal portion of the penile shaft are covered by thin muscles (Fig. 10-1). The paired ischiocavernosus muscles overlie the crura and corpora cavernosa. Another pair of muscles, the bulbospongiosus, overlies the corpus spongiosum.

Urethra and Glans. The urethra is named according to the part of the penis that it is traversing. Thus, in the penis the urethra is divided into bulbous, spongy, and glandular portions. The bulbous and spongy parts of the urethra are lined by a pseudostratified columnar epithelium, except at the tip of the penis, termed the *fossa navicularis*, which is lined by stratified squamous epithelium. The epithelium contains small acini of mucous cells (glands of Littre) as well as mucosal and submucosal glands termed *urethral* or *periurethral glands* (Figs. 10-2 and 10-3). These glands become infected and form abscesses.

On the superior surface of the corona of the glans penis, as well as on the undersurface near the frenulum, there are sebaceous glands, the glands of Tyson. These glands secrete a white cheesy type of material which with desquamating epithelial cells forms the smegma, a substance that accumulates between the prepuce and glans of uncircumcised men.

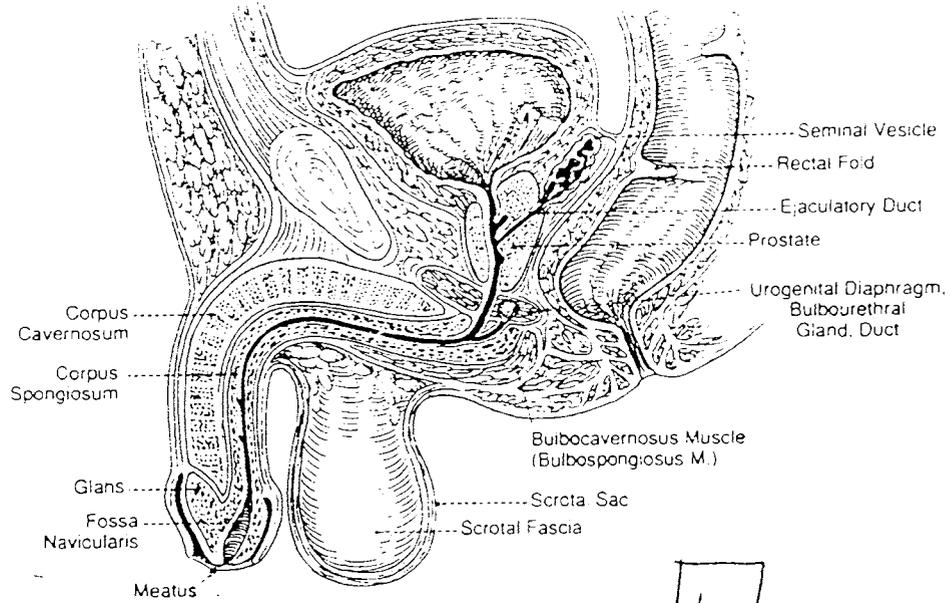
SCROTUM

Examination

Skin. The scrotum and its contents are examined next. Palpation of the scrotal skin may reveal small sebaceous cysts. These structures may be multiple and, on occasion, become quite large or develop infections. Malignant tumors of the scrotum are rare. In contrast, scrotal hemangiomas, bluish, vascular malformations, are common, and they may bleed spontaneously or following sexual activity. After the skin and subcutaneous tissues of the scrotum and perineum have been palpated, attention is directed to the intrascrotal contents.

Scrotal Compartments. The scrotum has two compartments which are divided in the midline. Each side is the mirror image of the other, and an identical examination is carried out for each

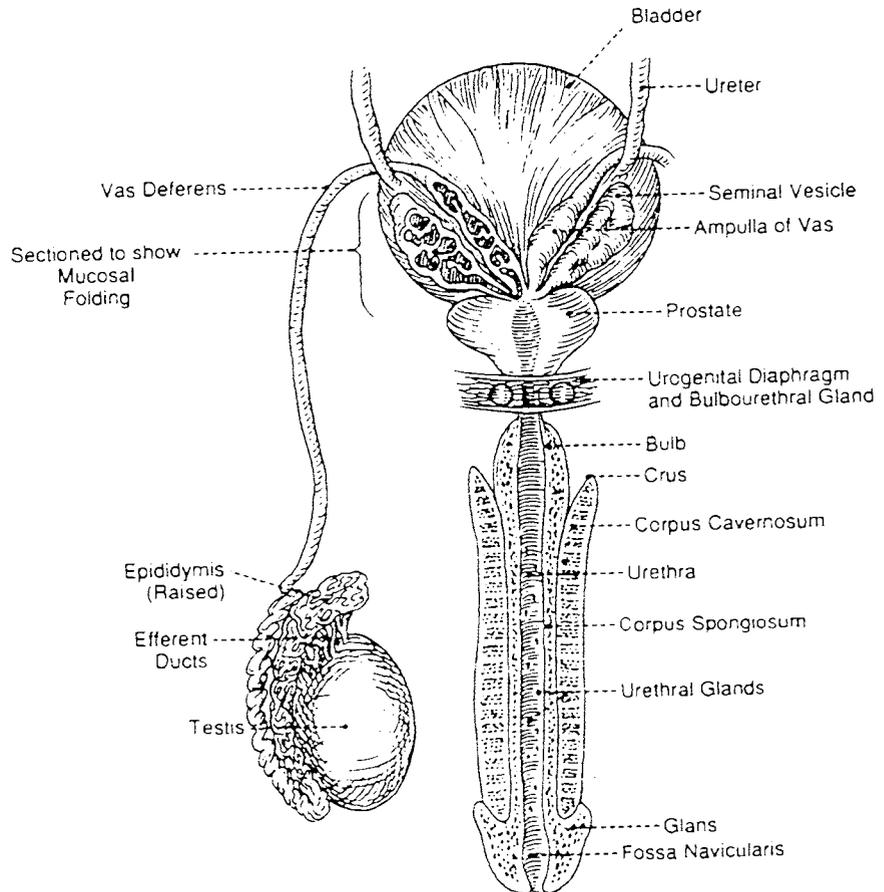
Fig. 10-1. Sagittal section of pelvis and male reproductive system.



scrotal compartment. The testis is the most anterior intrascrotal structure and must be examined carefully. The second most important structure in the scrotum is the epididymis, which lies immediately posterior to the testis.

Testis. Each testis should be palpated using two hands. Hard areas within the testicular parenchyma must be regarded as potentially malignant until proved otherwise. Testicular tumors are the most common genital urinary tract malignancy in men 20 to

Fig. 10-2. Coronal section of male pelvis and urethra viewed posteriorly.



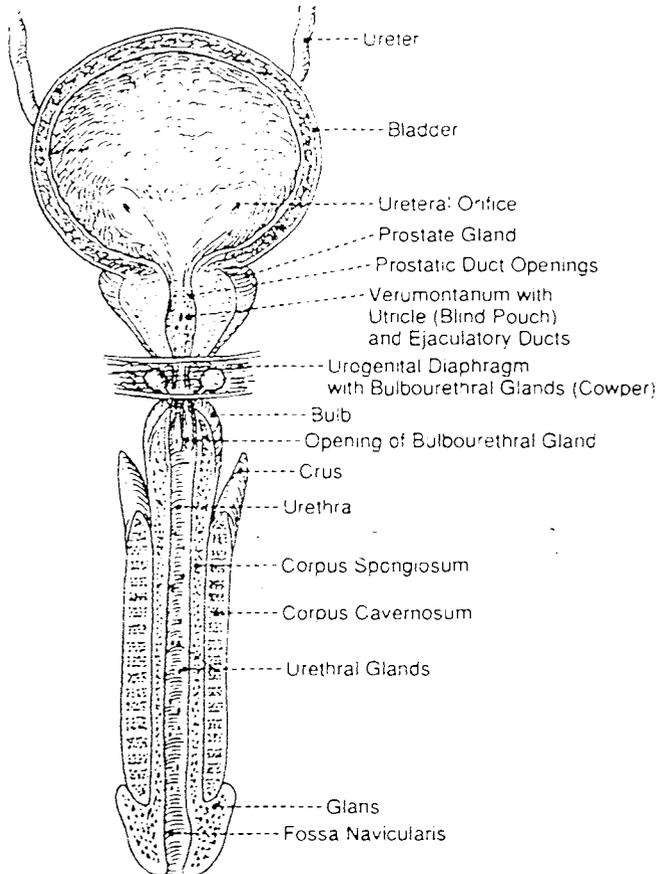


Fig. 10-3. Coronal section of male pelvis and urethra viewed anteriorly.

40 years old. Transillumination of all scrotal masses should be routine. The patient is placed in a dark room and a strong light is applied to the back of the scrotum. Light is transmitted well through benign cystic structures, such as hydroceles or spermatoceles, but not through solid mass lesions, such as testicular tumors. Tumors may be nodular in consistency but are often smooth. The testis that has been replaced by tumor or damaged by a gumma is often insensitive to pressure, and the usual sick sensation produced by firm pressure on the testis is absent. The testis may be absent from the scrotum as a result of maldescent during development, a condition known as *cryptorchidism*, or as the result of abnormal mobility within the scrotal sac and inguinal ring, a condition known as *retractile testis*. An atrophic testis is small and flabby in consistency and may be hypersensitive. This may be congenital; following treatment of an undescended testis; the result of previous infection, such as mumps orchitis; or may follow torsion or previous surgery, such as hernia repair. Although sperm production may not occur in these organs, hormone production may continue. Very small (1.5 × 1 × 1 cm), abnormally firm testes in a young adult usually are attributable to Klinefelter's syndrome, a relatively common condition present in 0.2 percent of men and is usually associated with infertility. Klinefelter's syndrome is associated with one Y and two X chromosomes. On occasion, the testis may twist within the scrotum, compromising its blood supply. This is termed *testicular torsion* and is one cause of acute scrotal pain and swelling.

Epididymis. The epididymis is a comma-shaped organ, that is usually applied closely to the posterior aspect of the testis. On occasion, however, the epididymis may be loosely applied to the testis. The epididymis should be carefully palpated for size, tenderness, and induration. Induration of the epididymis usually results from infection, as primary epididymal tumors are rare. It is often possible to feel the groove between the testis and the epididymis everywhere except superiorly, where the two structures are joined. During acute infections, the testis and epididymis are often indistinguishable, as both structures are involved in the inflammatory process. Tenderness is exquisite; swelling may be impressive and accompanied by an acute inflammatory hydrocele. In many men a small, ovoid mass, representing the appendix testis, a vestigial embryological structure, may be palpated near the groove between the upper pole of the testis and the epididymis. Occasionally, the appendix testis may twist, producing acute tenderness and swelling of the scrotum.

Spermatic Cord. The cord structures at the neck of the scrotum should be palpated between the thumb and index finger. The solid, ropelike vas is usually identified easily and may be followed to its junction with the tail of the epididymis. Other soft, stringy structures in the spermatic cord may be palpable but are usually not clearly defined. Swellings in the cord are usually cystic in nature (e.g., hydrocele or hernia) and are rarely solid (e.g., connective tissue tumor). Varicoceles represent collections of dilated veins, are usually present on the left side of the scrotum, are best demonstrated with the patient standing, and feel "like a bag of worms."

Anatomy

Testis. The testis fulfills two main functions: it produces sperm and it secretes male hormones. Production of sperm takes place in the seminiferous tubules, whereas the production of testosterone, the major male hormone, takes place in the tissue located between the tubules. Each testis contains approximately 400 to 600 seminiferous tubules. Individual tubules are up to 70 cm in length and are coiled along most of their length in order to be accommodated in a fascial compartment of the testis. These compartments are extensions of the outer fibrous capsule of the testis, the tunica albuginea. The seminiferous tubules join to form the rete testis, which is the connection to the excretory duct system. The lining of the seminiferous tubules contains two main types of cells, the developing sperm cells and the Sertoli cells, which support and presumably "nurse" the sperm cells during their development process. Sperm are continuously produced in the testis from puberty to senility following an orderly sequence of events. In the testis this process takes about 64 days. However, when they leave the testis, the sperm cells are immature and are unable to fertilize an egg.

Excretory Ducts. The excretory ducts transport sperm from the testis to the end of the male reproductive tract. The excretory ducts are composed of five elements, beginning from the testis: the efferent ducts, epididymis, vas, ejaculatory duct, and urethra.

Efferent ducts. There are approximately twelve efferent ducts, which are convoluted tubules connecting the rete testis to the epididymis. The epithelium lining the ductules contains both ciliated and nonciliated cells. Ciliary movement helps propel sperm toward the epididymis. On electron microscopy, the nonciliated cells are found to be lined by tall microvilli. Surrounding the

epithelium is a thin basal lamina, lamina propria, and smooth muscle fibers oriented circularly.

Epididymis. The epididymis receives the sperm and seminal fluid from each of the efferent ducts. The epididymis has three parts, the head, the body, and the tail. The initial segment of the epididymis is the head which fuses with the efferent ductules. The epididymis continues inferiorly along the posterior surface of the testis as the body of the epididymis (Fig. 10-2). At the inferior pole of the testis the epididymis thickens to form the tail.

Throughout its course the epididymis is lined by tall, thin columnar cells with nonmotile stereocilia. In electron micrographs the stereocilia are found to be exceptionally long filamentous microvilli. In addition, the fine structure of these cells is typical of a cell that is both secretory (abundant rough endoplasmic reticulum and Golgi cisternae) and absorptive (apical vesicles and tubules).

Within the epididymis, sperm undergo progressive maturation during their movement from the head to the tail. As sperm emerge from the testis they are infertile and relatively nonmotile. By the time they reach the tail of the epididymis, they are both motile and fertile. The average time of sperm transit through the epididymis is 12 days. The sperm and epididymal fluid together contribute about 10 percent of the ejaculate.

Vas. The vas is the continuation of the epididymal duct, with only slight modification of the epithelial surface but substantial thickening of the outer muscle coat. The thickness of the muscle coat produces the "whipcord" sensation when the vas is rolled between the thumb and forefinger during physical examination of the cord.

From the inferior pole of the testis, the vas ascends in the spermatic cord within the scrotum, until it reaches the superficial inguinal ring. After traversing the inguinal canal, the vas enters the preperitoneal space at the internal inguinal ring, where it courses inferiorly into the pelvis lying between the pelvic fascia and peritoneum. The terminal portion, or ampulla, of the vas is more dilated and fuses with the seminal vesicle to form the ejaculatory duct.

Ejaculatory duct. Traversing the substance of the posterior wall of the prostate, the ejaculatory duct opens into the prostatic urethra at the verumontanum, an oval-shaped mucosal excrescence.

RECTUM AND PELVIC ORGANS

EXAMINATION

Inspection may reveal presence of external hemorrhoids, rectal fissures, or fistulas. Internal examination is then carried out by inserting a well lubricated, gloved index finger into the anal canal. The sphincter tone is evaluated and the canal is examined for undue tenderness or induration. Presence of induration, rectal stenosis, or mass lesions may indicate the need for additional studies, such as anoscopy or proctoscopy.

With the patient bent over the examining table, the prostate and seminal vesicles are palpated through the anterior rectal wall. The normal prostate is about 4 cm in length and in width, about the size of the terminal segment of the thumb. The prostate is widest superiorly at the bladder neck. Two distinct "lobes" of the prostate are palpable, separated by a median sulcus, or indentation. Normally, the prostate gland is smooth, somewhat

mobile, and nontender. The consistency is rubbery and resembles the tip of the nose.

One major problem in the prostate examination lies in differentiating firm areas. Differential diagnosis of a firm area in the prostate includes cancer, calculi, infarction, granulomatous prostatitis, and nodular, benign hyperplasia. Even the most experienced examiner may have difficulty distinguishing among these possibilities on digital rectal examination.

Above the prostate it may be possible to feel soft, tubular seminal vesicles extending obliquely beneath the base of the bladder (Fig. 10-2). Usually, clear presence of seminal vesicles on rectal examination indicates a pathological process. Most commonly, these patients have pelvic tumors such as prostate cancer or acute infectious processes.

ANATOMY

Rectum

In the rectum, there are two to four permanent semicircular transverse folds of the mucosa, which are termed rectal valves. They neither serve as valves nor support the feces, as suggested by some investigators. These valves are readily observed during endoscopy but may be lacerated during blind instrumentation of the rectum.

Microscopically, the mucosa of the rectum is composed of columnar absorptive cells, although goblet-type mucous cells are interspersed among the absorptive cells. Invaginations of the epithelial surface form straight, tubular colonic glands equivalent to the glands of Lieberkühn seen in the small intestine.

Rectoanal junction

The rectoanal junction is not a discrete point but a region of longitudinal mucosal folds extending superiorly from a zone of mucosa that is paler and flatter (Fig. 10-4). This gives the appearance of a horizontal band with teeth, hence the term *pectinate line* (Latin *pecten*, "comb"). The mucosal ridges forming the toothlike character of the line are termed *anal folds* or *columns* (of Morgagni). At the pectinate line between the base of the anal columns, the mucosa is redundant and outpockets to form the anal crypts. The epithelium of the anus, i.e., distal to the pectinate line, is characterized by stratified squamous cells of the nonkeratinizing type.

Accessory sex glands

The male accessory sex glands include the seminal vesicles, prostate, and bulbourethral glands (Cowper's glands).

Seminal Vesicles. The seminal vesicles are paired, saccular glands with multiple foldings of their mucous membrane (Figs. 10-1 and 10-2). Embryologically they begin as tubular buds from the vas. Hence, the seminal vesicles join with the vas, forming a common ejaculatory duct.

The seminal vesicles are lined by columnar epithelial cells with abundant Golgi, rough endoplasmic reticulum, and secretory granules in the apical cytoplasm. The mucosal folds of the seminal vesicles are supported by a moderate lamina propria, containing collagen and elastic fibers. There is also a substantial muscular coat, which is important in the emission of secretions.

The seminal vesicles secrete an alkaline, slightly yellowish viscid fluid which constitutes 60 to 70 percent of the ejaculate vol-

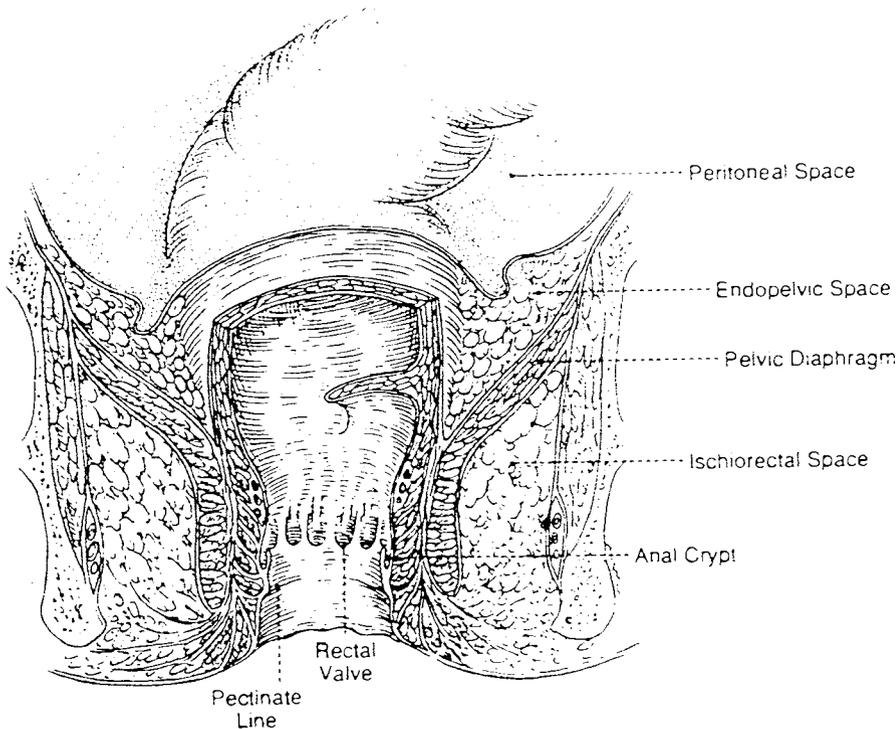


Fig. 10-4. Coronal section of male pelvis and rectoanal junction.

ume. Fractionation by "split-ejaculate" techniques shows that the semen consists of a presperm prostatic fraction, a sperm-rich fraction, and a postsperm vesicular fraction. Fructose and a variety of prostaglandins appear to be formed specifically by the seminal vesicle. Fructose is the principal energy source for sperm motility, but the role of prostaglandins in male fertility is uncertain.

Prostate. The prostate gland is located between the bladder neck and the urogenital diaphragm (Figs. 10-1, 10-2, and 10-3). The prostate completely encircles the urethra.

Zones. The prostate gland is composed of three zones of tissue: a periurethral zone, surrounding the urethra; a wedge-shaped central zone, bounded by the ejaculatory duct, urethra, and base of the bladder; and a peripheral zone, composed of all remaining glandular tissue.

The periurethral zone is composed of mucosal and submucosal glands penetrating the smooth muscle of the proximal urethra. Benign hyperplasia originates in this region and may lead to obstruction of urinary outflow from the bladder.

The central zone of the prostate is located between the urethra and ejaculatory duct. This area appears to be least susceptible to development of inflammatory, hyperplastic, or neoplastic disease.

The peripheral, or outer, zone is the portion of the prostate that is palpable on rectal examination. The peripheral zone is also the region of the prostate that is most frequently involved in carcinoma and inflammation.

Prostatic secretions. The prostate contributes approximately 30 percent of the ejaculate volume, in the form of a thin, slightly opaque fluid. The prostate gland appears to be important in protecting the male lower urogenital tract against infection, in providing enzymes for "liquefying" the semen after ejaculation, and in providing other components of the seminal fluid. Normally the pH of prostatic fluid is around 7. However, in men with well-documented bacterial prostatitis, the secretions alkalinize and

may reach or exceed pH 8. Zinc, magnesium, citric acid, and acid phosphatase in the ejaculate appear to originate in the prostatic secretions.

Bulbourethral Glands (Cowper's glands). These paired, pea-sized glands are located in the urogenital diaphragm (Fig. 10-2). Their excretory ducts drain into the posterior urethra. The glands secrete a thin mucoid material during the excitatory stage of sexual response, but the bulbourethral glands contribute only a minimal amount to the ejaculate. These glands are relatively immune to hyperplastic and neoplastic disease, although they can be involved in infections.

BLOOD SUPPLY

ARTERIAL PATHWAYS (INTERNAL ILIAC ARTERY)

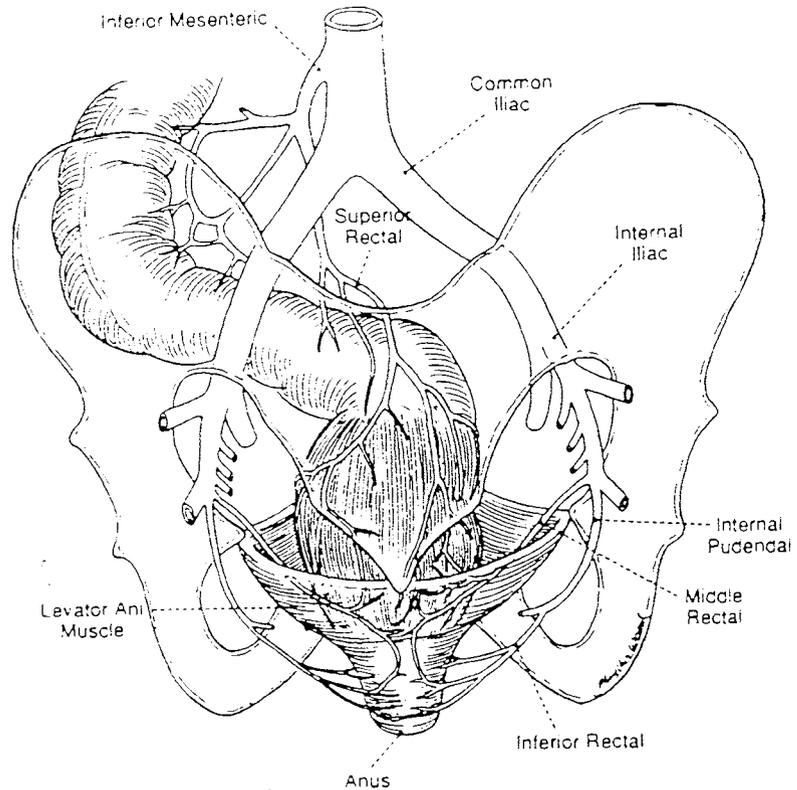
The pelvic organs in the male all receive their blood supply from the internal iliac artery. The internal iliac artery arises at the pelvic brim from the common iliac artery and immediately divides into an anterior and posterior division.

Posterior division

The posterior division of the internal iliac artery provides small branches to the pelvic sidewall and has three branches which leave the pelvis, including the pudendal arteries.

The internal pudendal artery supplies the perineum (Fig. 10-5). This includes all structures located in the ischiorectal fossa and superficial and deep pouches. As it leaves the pelvis via the greater sciatic notch, the pudendal artery gives off the inferior rectal artery and then enters the pudendal canal. The pudendal arteries have three areas of distribution: the anal canal, the perineum, and the phallus.

Fig. 10-5. Branches of the internal iliac artery and the distribution of the internal pudendal artery.



Anterior division

The anterior division of the internal iliac courses on the sidewall of the pelvis until it reaches the symphysis pubis, where it ascends the anterior abdominal wall. As it turns superiorly, the lumen of the vessel disappears and the vessel becomes a fibrous cord, the medial umbilical ligament. The internal iliac branches to form the middle rectal, superior, and inferior vesical arteries. The middle rectal artery supplies the rectum and has anastomosing branches with the superior rectal artery from the sigmoid. The superior vesicle artery supplies the fundus of the bladder whereas the inferior vesicle artery supplies the bladder neck, seminal vesicle, vas deferens, and prostate. All these vessels anastomose with their members from the opposite side.

VENOUS AND LYMPHATIC PATHWAYS

Pelvic organs

Venous Drainage. The pelvic organs have abundant venous plexuses which give rise to larger veins that parallel the arterial pattern. These veins return blood from the pelvic organs to the internal iliac vein which merges with the external iliac vessel to form the common iliac vein. This pathway joins the caval system of veins. Some blood in the perirectal region enters anastomotic channels in the mucosal plexus and ascends via the superior rectal vein to enter the portal drainage system.

Lymphatic Drainage. The lymphatic pathways from the pelvic organs follow the venous pattern. The first series of regional nodes are along the proximal parts of the internal iliac artery. From these nodes, lymphatic channels ascend to the aorta and the paraaortic lymphatic chain before entering the thoracic duct.

The sigmoid lymphatics follow the superior rectal veins to inferior mesenteric lymph nodes near the aorta.

Perineal structures

Venous Drainage. Most structures supplied by the pudendal artery are drained by veins that enter the internal pudendal vein. This vessel returns along a similar route to enter the internal iliac vein. There are two exceptions to this pattern: the anorectal region and the dorsum of the penis.

In the anorectal region blood may return via veins in the endopelvic space and eventually reach the vena cava through internal iliac tributaries or may continue superiorly to reach the superior rectal tributaries of the portal system. Increased venous pressure in this region, due to increased venous resistance in either the portal system or the caval system, can result in anorectal hemorrhoids. The anorectal submucosal venous plexus is also a pathway for the spread of infection from the perianal and rectal areas to the endopelvic space.

The second nonpudendal venous pathway from the perineum is via the dorsal vein of the penis to the prostatic venous plexus at the neck of the bladder. These veins cross the urogenital diaphragm from the perineum to enter the endopelvic space. The prostatic veins are tributaries of the internal iliac system.

Lymphatic Drainage. The lymphatic drainage of the perineum differs from its venous drainage. In essence, all the skin and superficial structures of the perineum have lymphatics which course via the medial aspect of the thigh to the superficial inguinal nodes. Thus, anal and perianal ulcers caused by syphilis, chancroid, herpes simplex virus, or lymphogranuloma venereum cause inguinal lymphadenopathy. Channels from these nodes penetrate

the fascia of the thigh at the saphenous opening to join the lymphatics from the leg. These lymphatic vessels course superiorly along the external iliac vein, then merge with paraaortic lymphatics.

An important exception is the lymphatic drainage of the testis, which does not follow the pattern described above. These lymphatics course superiorly in the spermatic cord, traverse the inguinal canal, and then ascend in the retroperitoneum with the testicular vein. In this manner the lymphatics reach the paraaortic lymph chain at the level of the renal vessels. This point is important clinically because metastases from testicular tumors do not cause inguinal adenopathy.

NERVE SUPPLY OF THE PERINEUM AND PELVIC ORGANS

The three neural components which must reach the perineal and pelvic structures are the somatic, parasympathetic, and sympathetic nerves.

SOMATIC NERVE SUPPLY

Only the perineum is supplied by somatic fibers. These arise in spinal cord segments S-2, -3, and -4 and travel via the pudendal nerve to all the skin and structures of the anal and urogenital triangles (Fig. 10-6). The pudendal nerve leaves the pelvis along with the pudendal vessels, entering the pudendal canal after giving off the inferior rectal nerves. These supply the perineal skin, external anal sphincter, and the skin of the anal canal. The pudendal nerve then divides into a perineal branch, supplying the deep and superficial pouch structures, and the dorsal nerve of the penis, supplying the skin of the penis. Branches of the perineal division supply the urogenital diaphragm, superficial perineal muscle, and skin of the scrotum.

PARASYMPATHETIC NERVE SUPPLY

The parasympathetic innervation of the pelvic organs is also derived from spinal segments S-2, -3, and -4. However, these fibers

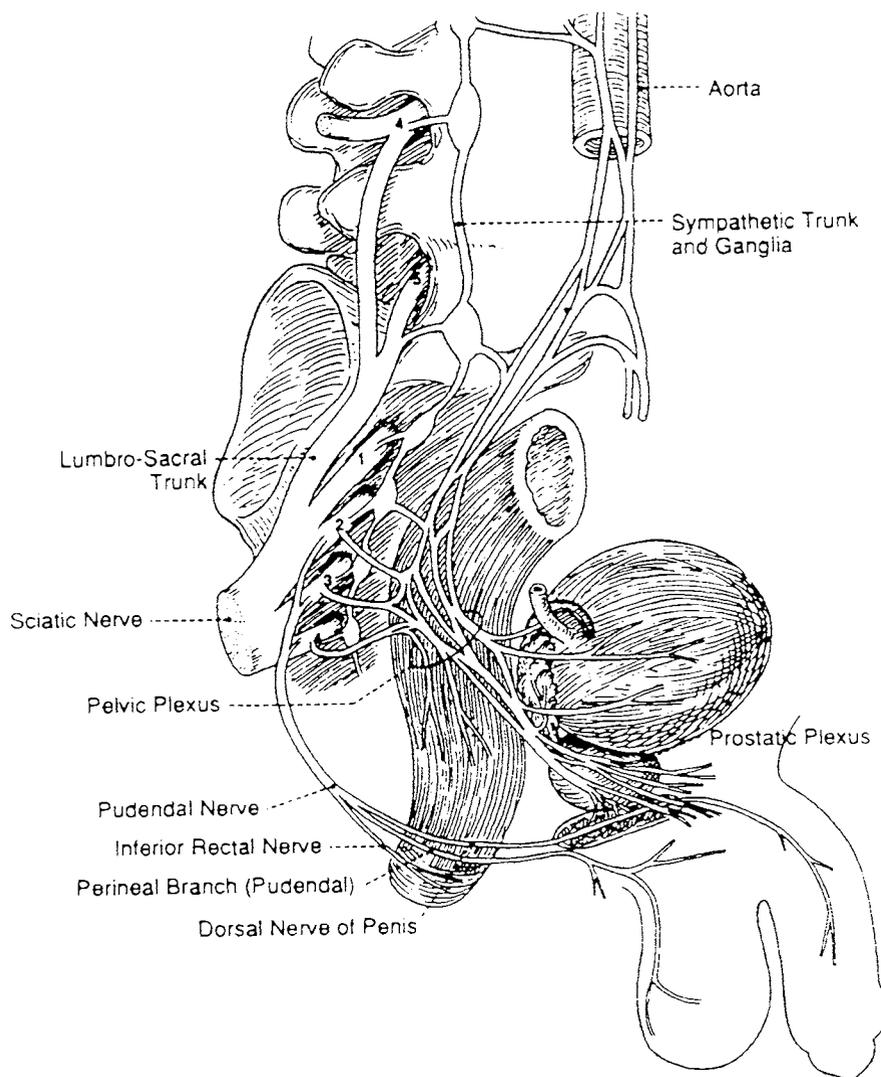


Fig. 10-6. Innervation of the pelvic viscera.

originate from neurons in the intermediolateral gray rather than the ventral gray, which is the origin for fibers in the pudendal nerve. After these fibers leave the anterior sacral foramina, they join to form the pelvic splanchnic nerve (nervi erigentes), which contributes these fibers to the plexus surrounding the viscera. This is termed the pelvic plexus. These fibers traverse the plexus without synapsing and enter the walls of the pelvic organs, rectum, bladder, and prostate, where they synapse in intramural ganglia. Short postganglionic fibers are then relayed to the muscle fibers.

SYMPATHETIC NERVE SUPPLY

Sympathetic fibers to the pelvic viscera are believed to originate in the intermediolateral gray of the spinal segments T-12 to L-2.

After joining a spinal nerve, they enter a sympathetic ganglion for that segment but do not synapse in the ganglion. The fibers descend briefly in the sympathetic chain, then course medially to enter the superior hypogastric plexus anterior to the aorta. The preganglionic fibers descend in the plexus to the inferior hypogastric plexus, which divides around the lateral sides of the pelvic organs and becomes the pelvic plexus (rectal, vesical, or prostatic). Synapses occur in the plexus or in the capsule of the organ innervated.

The pelvic plexus, therefore, is a mixture of parasympathetic and sympathetic fibers. In the region of the prostate, there is a group of fibers which course anteriorly at the upper edge of the urogenital diaphragm and supply the cavernous tissues of the penis (cavernous nerve). These fibers contain both parasympathetic and sympathetic components.

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May 26, 1996

To:
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Columbus, OH 43210

Dear Mr. Nagy:

Thank you for inviting me to consult with you. As you know, I am familiar with the Student Health Services because I supervised the design and execution of a study concerning genital warts in 1990 and also a survey of students about the Student Health Services in 1993. The study on genital warts utilized the data and medical records of the O.S.U. Student Health Services.

Please see the attached document.

Sincerely,

[REDACTED]

The Incidence of Medical Complaints at the
O.S.U. Student Health Services

Mr. Nagy:

The question that you raise is an interesting one, specifically: how does Dr. Strauss' record compare to that of all other physician's at the Student Health Services in terms of complaints of a sexual nature made by student-patients. Judicial outcome of the complaint process is not considered in this document.

Since the University has not given you any data on this matter, I have proceeded on the basis of interviews and by estimating certain data, as stated, in a manner which I believe to be reasonable. Following are three samples of complaint rates, followed by the outline of a simple study which could be executed by the University if it wishes to obtain accurate data for verifiable conclusions.

The result of each of the following samples is expressed as "complaints/1000 patient-visits". "Complaints" means complaints of a sexual nature made by the patient against the examining physician, brought to the attention of the Director or Assistant Director of the Student Health Services. A "patient-visit" means one visit to a physician for a medical problem that requires a physical examination of the patient's genitalia, for example, a urethral discharge or a rash in the genital area. Only visits made by men and complaints filed by men are considered.

The patient's medical problem is reflected by the diagnosis code entered by the physician on the patient's medical record, for example, "nonspecific urethritis" or "scabies". The results are expressed "per 1000 patient-visits" in order to use a common method of comparing medical data.

Sample 1. Dr. Strauss worked as the founding director of the Men's Clinic from October 1, 1993, through January 8, 1996: 27 months. He calculates that he had 1,500 patient-visits in the calendar year 1995. All of these visits required a genital examination. The daily number of visits to the Men's Clinic increased somewhat during Dr. Strauss' directorship. Thus, we estimate that Dr. Strauss had a total of 3,000 patient-visits in 27 months. During this time, 3 complaints were made against him, resulting a complaint rate of 1 complaint/1000 patient-visits.

Sample 2. ██████████ M.D., was the Acting Director of the Student Health Services for the 18 months prior to Dr. ██████████ assuming the directorship in 1992. Dr. ██████████ agreed to be interviewed.

We estimate that patients with "men's problems" were seen during this period at a rate two-thirds of that following the creation of the Men's Clinic by Dr. Strauss. This seems reasonable because the Men's Clinic appeared to attract more men for treatment at the Student Health Services than was previously the case, including men who otherwise would have sought treatment at the Columbus Health Department's Sexually Transmitted Diseases Clinic or from another physician.

We calculate that 1333 patient-visits occurred during Dr. ██████'s 18-month directorship (see footnote 1). Dr. ██████ recalls approximately 6 complaints of the nature studied here during that period. (Dr. ██████ says that this is verifiable in the Student Health Services' Quality Assurance records). Thus, there were 4.5 complaints/1000 patient visits.

Sample 3. While Dr. Strauss was the Director of the Men's Clinic, Dr. X. worked with him on a continuous, part-time basis. Dr. X. had approximately one-tenth the number of patient-visits that Dr. Strauss had. Thus, we estimate that Dr. X. had 300 patient-visits during the 27 months that Dr. Strauss was director and an additional 100 patient-visits to date, for a total of 400 patient-visits.

Dr. Strauss is aware of 2 complaints against Dr. X. that reached Dr. ██████ during this period. (It is possible that there were others, of which Dr. Strauss is not aware.) Thus, the complaint rate is 2/400 or 5 complaints/1000 patient-visits. This is about the same complaint rate as in Sample 2.

Conclusion. Dr. Strauss has a complaint rate approximately one-fifth that of all other physicians at the Student Health Services (Sample 1); and approximately one-fifth that of the other physician who worked in the Men's Clinic (Sample 2).

It appears to me that Dr. Strauss should be praised, rather than punished, for his exemplary ability to maintain an unusually low record of complaints in an area of medical practice that is at extremely high risk for complaints due to its sensitive nature. This record was maintained even though Dr. Strauss had many more patient-visits per month for sexual problems (ten times or greater) than any other physician.

Recommended Studies. The University can verify all of the above numbers if it wishes to do so.

In addition, a study design that would yield accurate results is as follows. 1) Determine the exact number of patient-visits to Dr. Strauss at the Men's Clinic. Then calculate the complaint rate as described above. 2) Find the same number of patient-visits to all other physicians for "men's problems" before and after Dr. Strauss was practicing in the Men's Clinic. Determine the number of complaints during these periods.

Calculate the complaint rate as described above. The conclusion is expected to be similar to that described above.

Footnote 1. $(3000 \text{ patient-visits}) / 27 \text{ months} \times (18 \text{ months}) \times 2/3$
= 1333 patient-visits.

(End)

3

Student Health Services
The Ohio State University

Men's Clinic Form

Last	First	MI
ID#		
(Place patient label here)		

To: Patients new to the Men's Clinic
From: The Doctors of the Men's Clinic

In order for us to communicate more clearly, please answer the following questions(••). In many cases you can simply circle the answer you like. You can skip any question that you prefer not to answer. We can discuss such questions in person if you wish.

••What is the problem that brings you in today?

••Have you had this problem before? (Circle one.)..... Yes.....No

••Have you had a sexually transmitted disease before? Yes.....No
If yes, what was it? _____

••Have you had a urinary tract infection before? Yes.....No

••Have you had an injury or abnormality of a testicle? Yes.....No

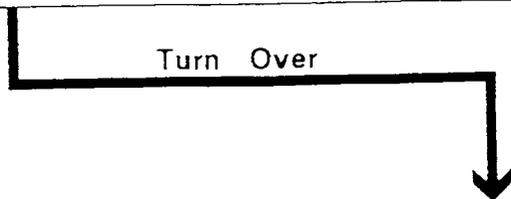
••Have you had a problem related to the prostate, rectum, or anus? ... Yes.....No

••Have you had surgery, for example, hernia? Yes.....No

••Have you had any other serious medical problems? Yes.....No

••Are you taking any medications now?..... Yes.....No
If yes, what? _____

••Are you allergic to any medications? Yes.....No
If yes, what? _____



The physical examination that we perform in the Men's Clinic is tailored to the specific problem that you tell us about. It generally includes the following parts of the body. However, if you prefer that a specific area not be examined, please cross it out of the following list:

- 1) Skin of upper body. This is done because skin problems below the waist sometimes are related to skin problems above the waist. Lymph nodes (glands) of the neck and under the arms are felt at the same time.
- 2) Skin of the pubic area and genitals, including the penis and scrotum. Contagious diseases such as warts are sometimes visible.
- 3) Feeling both testicles for lumps, for example, cancer.

We hope that our discussions will make the diagnosis and treatment of your problem clear to you. Please interrupt us at any time with questions or suggestions. You may need to return to the Men's Clinic for further treatment, test results, or follow-up on another day at your convenience. We like to make sure that your problem has resolved.

Patients occasionally find that they would feel more comfortable working with a doctor different from the one to whom they have been assigned. That is no problem. Just mention at any time that you would like to switch and it will be done. We don't mind. If you need to make a return appointment, you can choose any doctor you wish.

Sometimes a technician or medical student works with us.

••Do you prefer that such a person be (circle one):

- Present
- Not Present
- Don't Care

There are sometimes costs to you associated with procedures performed in this clinic. Please be sure you have discussed and understood these costs before the procedure.

Patient's Signature

Date

When you have completed this form, keep it and hand it to your doctor. Do not give it to the receptionist.

4

Redacted

O.S.U. Student Health Service

Men's Clinic---January 5, 1996

S---The patient has a regular girlfriend who was treated for bladder infection 2-3 weeks ago. For the past 3 days he has noted mild urethral burning with urination and no urethral discharge. He has no other signs or symptoms.

O---Skin of upper body is unremarkable. Inguinal lymph nodes are unremarkable. Right and left testes are descended, normal in size and consistency, and not tender. Right and left epididymis and spermatic cords are normal and not tender.

Uncircumcised. Pubic, genital, and crural skin appears normal. At initiation of skin exam the patient became erect and ejaculated. Did urethral TM culture and chlamydia probe.

I explained planned treatment with Doxycycline. I asked if premature ejaculation had been a problem with his girlfriend. The patient became angry and left the room.

A---Nongonococcal urethritis (9940)

P---I discussed the incident with Dr. treated by Dr.

Patient was seen and


Richard H. Strauss, M.D.

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behavior. Because peer group activity is a strong predictor of the activity of any of its members, a discussion about peers' behavior can give indirect evidence of possible patient needs.

- d. *Comparative approach:* Nonverbal patients in particular may do better with a comparative, "multiple choice" approach. "How would you rate your home, school performance, (and so on) with that of others?" Alternatively the physician might ask, "Do you feel about the same or more troubled about x than most of your friends?"

PHYSICAL EXAMINATION

A complete physical examination proceeds along traditional lines and is outlined in Table 4-2. Here, too, the physician is left to construct his or her own best method of recording this data. The

following are particular points to be noted in performing the examination:

1. Respect the adolescent's privacy. Use proper draping and avoid unnecessary exposure. Keep the doors to the examining room closed, and do not open them until the teenager is dressed or until the curtain of the changing area is pulled. When the physician is of a different sex than the patient, a same-sex chaperone may be advisable for particularly anxious adolescents. A parent should be permitted to remain in the room if the adolescent makes this request.
2. The physical examination is a good teaching tool as well as an opportunity to provide useful reassurance. Talking throughout the examination and explaining the procedures increases the adolescent's knowledge about his or her body and diminishes the level of anxiety.
3. The touching involved during the physical examination may be sexually stimulating. This is

TABLE 4-2. PHYSICAL EXAMINATION OF ADOLESCENTS

Note: It is helpful to accompany the examination with a running commentary as you go along, particularly to point out normal findings: "Your heart is fine. Your blood pressure is perfectly normal. I don't feel anything in your belly that shouldn't be there." If you encounter pathology, you can note this and follow up in postexamination discussion: "Your ear looks a little infected. You do have a slight heart murmur. Your liver is a little enlarged. We'll go over this in a minute."

Examination should proceed in a cephalocaudal manner, leaving genitalia until last. Particular points to be emphasized in the adolescent are the following:

- Height, weight, and blood pressure: Blood pressure may be somewhat labile. If elevated initially, repeat later when patient is dressed and when anxiety level is lowest.
- Physical and mental status: Apparent health, mental functioning, mood, and affect
- Sexual maturation rating (Tanner stage)
- Skin (acne): Note location, extent, degree (comedones, pustules, cysts), and activity (healing/active)
- Eyes: Visual acuity important; may develop myopia during growth spurt
- Ears: Auditory acuity (tuning fork, ticking watch)
- Mouth: Dental decay and periodontal disease a major problem
- Thyroid: Enlargement, nodules, bruit
- Breasts: Development, symmetry, masses (usually fibroadenoma). Girls should be taught self-breast examination during the inspection of their breasts.
- Heart: Function murmurs common
- Abdomen: Can inspect pubic hair escutcheon for rating maturation at at this time. Divert ticklish or tense patients by talking about something pleasant while palpating: "Tell me what you like to do best. Tell me about your best friend. Do you have any pets?" This may help relax the abdominal wall.
- Musculoskeletal: Scoliosis should be looked for in all.
- Genitalia: Boys always; girls when indicated (e.g., all sexually active girls and those with any symptomatology should have external inspection and internal pelvic examination.) Desirably, all adolescent girls should have a pelvic examination at some time as a matter of routine (may encounter problems in some cultures and should respect). Daughters whose mothers took diethylstilbestrol (DES) during pregnancy should be referred for culposcopy. Boys should be taught self-testicular examinations during the inspection of their genitalia.
- Rectal: Sexually active males (may have enlarged prostate from inadequately treated or asymptomatic gonorrhea); symptomatic males; sexually active and symptomatic girls. Introduce for all adolescents at some point in health maintenance plan.



Stage I

Stage II

Stage III

Stage IV

Stage V

most apparent in teenage males who develop an erection. This type of reaction is usually not a result of the adolescent's feelings toward the examiner but rather is an uncontrollable natural reflex. It is best not to ignore these reactions but to explain them to the teenager in a matter-of-fact, professional manner. This will lessen embarrassment and misconception.

The pelvic examination in girls and the rectal and genital examination in boys are often deleted in an effort to spare the teenager embarrassment. In doing so the physician misses an important opportunity to reassure the adolescent about normal conditions, may overlook significant physical findings, reinforces myths and fantasies about these areas, and conveys the impression that he or she views the genital region as special and taboo. When the advantages afforded by examination of these parts are explained, the patient usually does not object. Although the pelvic examination should be considered part of a complete examination and should not warrant separate consent, separate consent may be appropriate in some families and is a matter for individual assessment.

5. Special attention should be paid to evaluating pubertal development. Figures 4-2 through 4-4 provide a guide for this purpose. The patient's sexual maturity rating should be recorded routinely on a chart.

CONCLUDING THE VISIT

Adolescents will imagine the worst if not presented with honest facts; however, such honesty can prompt poor compliance if resulting overconcern produces denial or hypochondriasis. Avoid a conspiracy of silence. Full and careful explanations of procedures in straightforward terms will counter the adolescent's proclivity for distortion and misinterpretation. Pictures and diagrams are helpful, as is writing things down for later review.

Adolescents need to know what is going on and what the physician thinks about them and their condition to feel that they are not losing control. Interpretation of findings and a discussion of

plans should be done directly with the patient at the end of the visit. Parents can then be brought into the room and nonconfidential matters reviewed. The physician can also effectively reinforce the patient's understanding and sense of control by asking the teenager to relay the earlier discussion and management plans to the parents.

In so far as possible the patient should be in charge of the therapy (e.g., taking medication, following regimens and diets); in the case of special diets, the persons who purchase food and prepare meals must assist. Although parents should be advised of therapeutic plans, unless confidential, they should be encouraged to allow the patient to exercise as much responsibility as possible. Directions should be given in clear, careful, and unambiguous terms. Patients need to know what to take and why as well as what to do, how to do it, when, and for how long. Patients should receive such information in written form. Finally, the physician should make sure the patient has enough medication.

The need for further visits should be clearly stated and directions given for interim attention if needed. The physician should try to avoid multiple specialty referrals or test procedures within a short span of time. Care needs also should be integrated with school and social activities. For example, patients should not have to schedule physician visits during examinations or other critical school times.

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Adolescent Medicine

Second Edition

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6

Clinical and Therapeutic Studies in Premature Ejaculation

By ALAN J. COOPER

THE PSYCHIATRIC LITERATURE offers widely divergent views on the causation, treatment and prognosis of premature ejaculation. For example, numerous psychiatrists see the condition as a neurosis,^{1,2} while others see it physiologically as a "heightened, or exaggerated reflex" which may reflect "sexual hypertonus" or high sex drive.^{3,4} Schapiro, who studied 1130 cases, considered most cases were "psychosomatic;" in a few, however, he indicated functional hyperaesthesia of the glans; or a shortening (normal anatomical variation) of the frenum.⁵ An extreme but nonetheless fascinating view was propounded by Kinsey, et al., who considered premature ejaculation to be a "highly adaptive and superior trait" since in a biological sense it was conducive to perpetration and survival of the species.⁶ While it would be difficult to contest the biological validity of Kinsey's argument, it would perhaps seem to many an inappropriate use of terminology since many men possessed of this "superior trait" become extremely distressed and believing themselves to be sexually inadequate seek out treatment.

Recent or current treatments of premature ejaculation are varied and numerous; included in the spectrum are formal psychoanalysis,² behavior therapy,⁷ application of a local anaesthetic to the glans penis,⁸ "physiological" treatments^{4,9} and various systemic drugs, including sedatives and tonics⁵ and the M.A.O.I. antidepressants, isocarboxazid ("Marplan") and iproniazid ("Marsilid").¹⁰ Many workers have noted that phenothiazines and especially thioridazine ("Mellaril") can delay or inhibit orgasm and ejaculation.¹¹⁻¹³ At least one clinical trial of its efficacy in that condition has been completed.¹⁴

The prognosis of premature ejaculation is equally indeterminate, from some authorities claiming 100 per cent cure rates,^{2,4,14} through the more modest rates of Schapiro,⁵ Mellgren^{14a} and Johnson,¹⁵ 75 per cent and 23.5 per cent, respectively, to the utterly pessimistic "never having cured a single case" of Hastings.¹⁶

The aims of the present study are to define the developmental history, clinical and psychological features in a group of patients who presented in a psychiatric outpatient department with a "primary" complaint of premature ejaculation; to assess the efficacy of brief essentially practical (minimum 20 fortnightly sessions over one year) therapy in these cases; and to suggest a classification of premature ejaculation.

DEFINITIONS

In the present study, premature ejaculation refers to the persistent occur-

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rence of orgasm and ejaculation before or immediately following penetration of the female during coitus, which occurred against volition and before the male wished it. "Primary" refers to premature ejaculation being the main or the only presenting symptom. Precipitancy in association with anatomical abnormality, or previous or present disease of the genito-urinary tract, chronic medical conditions, organic disease of the C.N.S., psychoses or drug addictions were excluded. For most authorities, primary would be synonymous with psychosomatic and implies that psychological factors are causally significant.

PATIENT POPULATION

Thirty patients satisfied the criteria of presenting in a psychiatric outpatient department with a complaint of premature ejaculation and attended a minimum of 20 fortnightly treatment sessions. Although there was some degree of overlap clinically, it was possible to identify three fairly discrete groups designated for convenience of description and cross-reference as "Types 1, 2 and 3."

"Type 1: Premature Ejaculation with Good Erections, Present Since Adolescence"

This group was composed of ten men, nine married and one single, in whom premature ejaculation was the dominant symptom. Erectile insufficiency had never been a problem in these patients. At referral, the mean age was 28.3 years (range 23-30 years). In nine cases, the decision to seek advice had been instigated by the female spouse. Most of this group had experienced premature ejaculation constantly since adolescence, but it had only become recognized as a "medical problem" following marriage when the majority of the female spouses had complained of sexual frustration due to the male's precipitancy. "Type 1" had a higher frequency of coital outlets (mean 3.8 per week) than either "Type 2" (2.5) or "Type 3" (2.3) (Table 1). However, despite the suggestion of a higher sex drive, only one out of ten of "Type 1" subjects had been able to perform coitus more than once on any single occasion of sexual activity, compared with three out of seven, and five out of 13 in "Types 2 and 3," respectively. The capacity to experience multiple orgasms in a limited period of time without an intervening refractory period correlates with high sex drive.⁹ "Type 1" premature ejaculators experienced normal or enhanced sexual desire in the coital situation. Spontaneous erections, often on the slightest stimulation, were common and often embarrassing. On a psychological test (N.S.Q.)¹⁷, the mean "neurosis" and "anxiety" scores of 6.6 and 6.9 sten respectively indicated a definite tendency toward a neurotic diathesis. (Normals score between 4-7 sten.¹⁷) Clinically, several of "Type 1" patients were suffering from an anxiety psychoneuroses with prominent somatic manifestations (sweating, palpitations, dry mouth, tremulousness) which was severe enough to warrant independent treatment.

6

"Type 2: Acute Onset Premature Ejaculation with Erectile Insufficiency"

Seven patients composed this group. The mean age at referral, mean duration of the disorder and the mean age at onset is set out in Table 1, which also shows the mean N.S.Q. score(s) for "neuroticism" and "anxiety." In this type,

Table 1.—Vital Statistics and Other Data According to Type of Disorder at Referral

Type of Premature	Mean Age	Mean Duration	"Neurosis" (N.S.Q.)—Mean	"Anxiety" (N.S.Q.)—Mean	Sex Drive ⁹ — Sexual Outlets	Mean Age of Puberty ¹
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the disorder of premature ejaculation had come on acutely, seemingly in response to a discrete physical or psychological precipitant. Unlike "Type 1" patients, it had often occurred in a setting of erectile insufficiency which had in fact been the dominant manifestation. Less frequently, premature ejaculation had occurred with normal erections. Despite the coexistence of impotence, all had experienced normal sexual desire in the coital situation. The capacity to respond erotically was suggested by other factors, as most continued to masturbate themselves to orgasm with adequately formed erections and without premature emission. The most impressive and constant psychological feature was fairly high levels of anxiety during coital activity which seemed in large measure a significant cause of the precipitancy. Many of these subjects were comparatively inexperienced and sexually ignorant. Some were severely inhibited.

"Type-3:" Premature Ejaculation with Insidious Onset Impotence or Impotentia Ejaculandi: Delayed or Absent Ejaculation

Statistics relating to these patients are seen in Table 1. In this group, in the vast majority of cases, premature ejaculation occurred in a setting of a poorly formed or absent erection which dominated the clinical picture. On only a few occasions had precipitancy been associated with a strong erection. It should be emphasized, however, that this situation was a rarity. Developmentally, patients in this group had tended to show a gradual falling off in erotic interest and performance over months or years. Many seemed to have low sex drives (Table 1) and several had experienced potency problems including premature ejaculation during early sexual experience in the first few years of marriage. The most significant feature of these patients was a marked decline in sexual interest and responsiveness. They were only rarely roused by provocative stimuli and such arousal was often not sustained. Although some degree of emotional desire might have been evoked during coital attempts, erections were ill-formed, and when ejaculation occurred, it was usually premature. Anxiety, when present, was usually less intense than in "Types 1 and 2" and had often developed months or years after the premature ejaculation had become established. Although it seemed the consequence of, rather than the cause of, the precipitancy, it nonetheless tended to exacerbate that condition.

SUMMARY OF PRESENT TREATMENT METHODS

Therapy was designed empirically according to the specific findings in the individual case. It consisted of an optimum permutation of the following five principles. Table 2 summarizes the methods of combination for the three clinical types of premature ejaculation.

(1) Muscular relaxation was prescribed especially in cases where high levels of coital anxiety was in evidence and/or strong erections and high levels of sexual tension were the rule ("Types 1 and 2"). The full methodology has been described elsewhere¹⁸ and is based on the tenets of Jacobson.¹⁹ In essence, the patient is taught the art of inducing deep muscular and concomitant mental relaxation in himself as a method of reducing or inhibiting reciprocally anxiety,

Table 2.—Method of Com

Treatment Combination
Deep muscular relaxation
Extra vaginal stimulation (Sem
Sexual education
Provision of novel and "excite
Psychotherapy
Totals

+, ++, +++ indicates

anger or other disruptive
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 (5) Psychotherapy wa
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Table 2.—Method of Combination of Treatment Principles According to Type of Disorder

Treatment Combination	Type of Premature Ejaculation		
	"Type 1"	"Type 2"	"Type 3"
Deep muscular relaxation	+++	+++	++
Extra vaginal stimulation (Semans ⁹)	+++	+++	—
Sexual education	++	+++	+
Provision of novel and "excitatory" sexual stimulation	—	+	+++
Psychotherapy	++	++	++
Totals	10	7	13=30

+, ++, +++ indicates degree of emphasis.

anger or other disruptive emotions, which may be capable of provoking premature ejaculation. Initial training was carried out in the clinic, and each patient was advised to practice muscular relaxation at home and in any other appropriate situations. When able to induce relaxation quickly and certainly, as a prerequisite to attempting coitus, he was instructed to use this technique during pre-coital love play. The object was to become physically roused with a strong erection while remaining mentally composed.

(2) Extra vaginal stimulation was prescribed especially as in the case of muscular relaxation for cases with high levels of anxiety and/or good erections ("Types 1 and 2"). The procedure devised by Semans consists of encouraging the female partner to provide extra vaginal manual stimulation of the erect penis until the male experiences the sensation premonitory to ejaculation. At this point, stimulation is interrupted and the sensation is allowed to dissipate.⁹ When this has happened, stimulation is recommenced until the feeling again develops. Again it is allowed to die away. According to Semans, repeating this procedure will eventually allow ejaculation to be delayed indefinitely.

(3) Sexual education was especially relevant in "Type 2" premature ejaculation, in which ignorance and/or misinformation was common. Sex education consisted mainly of factual knowledge relating to male and female sexual anatomy, physiology, and psychology. Preferably and whenever possible, both partners were seen separately and then jointly. They were encouraged to ask questions relating to concepts of sexual normality, inhibition, and acceptability of practices.

(4) Provision of novel and excitatory sexual stimulation was important especially for "Type 3" patients, in which premature ejaculation occurred in the setting of sexual apathy, low responsiveness and poor or absent erection. The female was encouraged, as far as she was able, to provide stimulation of a greater intensity and variety than before in an attempt to induce a resurgence of sexual interest, concomitant improvement in erections, and hopefully, a resultant retardation in the speed of ejaculation.

(5) Psychotherapy was essentially superficial. Emphasis was placed on explanation, education, reassurance, support and developing and maintaining motivation. It was given to both partners, either individually, or if indicated, in a joint interview of up to one hour every two weeks. The first two or three

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METHODS

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psychotherapeutic interviews had three main functions: to gain as full an understanding as possible of the relevant psychopathology, to ensure that the treatment requirements the therapist considered conducive to a favorable outcome could as far as possible be met,* and to decide on the precise composition of therapy and to initiate it as soon as possible. Later psychotherapeutic interviews consisted mainly of discussions with the patient and/or his sexual partner relating to his progress in treatment and a consideration of any matters arising out of this.

Those patients who seemed to be responding satisfactorily and who reported an improvement in their condition (in the company of their spouses) had their success reinforced by praise and encouragement commensurate with the degree of improvement and were reassured that a favorable outcome was likely. They were advised to carry on with treatment strictly according to schedule in order that the male might develop increasing confidence in the coital situation which would grow with each satisfactory experience. The female partner was especially commended for her selfless cooperation and active participation in therapy and encouraged to continue her role until such time as the male's ejaculation had slowed sufficiently for both their liking. Emphasis was placed on the "gradualness" and "progressiveness" of the treatment exercise and both partners were advised against undue haste since a failure to observe the treatment principles would possibly result in failure and a consequent setback. Other issues such as nonsexual marital difficulties, if and when they were considered to be relevant by the therapist, were discussed and analyzed. The therapist's role in these circumstances was to catalyze frank discussions between the partners, with the hope that both might gain understanding into the nature of their difficulties and a consequent sincere desire to try to improve the situation.

In those patients showing unsatisfactory or no progress in treatment, the therapist's method was one of exploration and superficial analysis aimed at unearthing psychological factors that might have been responsible for the failure to improve. If the material that emerged during this probing indicated specific obstacles, remedial measures were introduced whenever possible. If no such obstacles could be unearthed by fairly superficial examination, subsequent interviews were devoted to boosting a patient's morale and encouraging him and his partner to persist with the practical advice given; for example, relaxation techniques. While this aspect was emphasized, it was made clear to the patient that at any time during an interview, he could introduce any topic he wished to discuss whether it seemed relevant or not.

These five principles were blended into a "physiologically oriented" therapy according to the findings in the individual case. It should be emphasized that these principles were applied flexibly, not concurrently or in any particular order. As treatment progressed, and in the light of new data derived from increasing knowledge of the patient, and amelioration or exacerbation of symptoms, the treatment principles were constantly reappraised and changes

* Treatment was offered to all patients regardless of whether they were considered good or bad risks.

PREMATURE EJACULATION

Table 3.—Outcome

Type of Disorder
"Type 1" premature ejacul.
"Type 2" premature ejacul.
"Type 3" premature ejacul.
Totals
Per cent (to nearest %)

in emphasis were made but as a dynamic phenomenon in response to the feedback of a variety of reasons, the need for the female to cooperate. Treatment was applied because the author believed effective, should produce of sexual disorders (in vaginismus in the female three months. Thereafter

Assessment was made possible, this was based patients were classed either delayed during coitus for which was psychological. For the purposes of statistics were combined.

Table 3 shows the outcome. Acute onset of treatment (mean time while premature ejaculation adolescence ("Type 1" sessions). Premature ejaculation in intermediary position sessions). The difference significant at better than other comparison reaction (43%) lies between. Although an oversir developmental histories etiologically discrete support from the outcome

Table 3.—Outcome of Treatment According to Type of Disorder

Type of Disorder	Outcome			Totals
	Improved	Unchanged	Worse	
Type 1 premature ejaculation	1	8	1	10
Type 2 premature ejaculation	6	1	0	7
Type 3 premature ejaculation	6	6	1	13
Totals	13	15	2	30
Per cent (to nearest per cent)	(43%)	(50%)	(7%)	(100%)

in emphasis were made if indicated. Treatment was seen not as a static process but as a dynamic phenomenon in which minor modifications were made in response to the feedback derived from the patient and his spouse. For a variety of reasons, the most important of which was inability and/or refusal of the female to cooperate fully, optimum therapy was not possible in every case.

Treatment was applied for a minimum period of one year, a period chosen because the author believes that psychiatric treatment, if it is to be considered effective, should produce improvement within this time; and in previous studies of sexual disorders (impotence and nonconsummation of marriage due to vaginismus in the female²⁰), maximum improvement occurred within the first three months. Thereafter, further improvement was negligible or absent.

LEVELS OF RECOVERY

Assessment was made after a minimum of 20 therapeutic sessions. Whenever possible, this was based on the testimony of both the male and the female. Patients were classed either as improved, if ejaculation could be consistently delayed during coitus for at least twice as long as at the time of referral and which was psychologically more satisfying to the male; unchanged; or worse. For the purposes of statistical computation, the unchanged and worse groups were combined.

RESULTS AND DISCUSSION

Table 3 shows the outcome of treatment in relationship to the type of presentation. Acute onset premature ejaculation ("Type 2") had the best outcome of treatment (mean time to maximum improvement: four treatment sessions), while premature ejaculation which had been present constantly throughout adolescence ("Type 1") had the worst (one case only improved after ten sessions). Premature ejaculation with insidious impotence ("Type 3") occupied an intermediary position (mean time to maximum improvement: 15 treatment sessions). The difference in outcomes between "Types 1 and 2" was statistically significant at better than the 1 per cent level (Fisher exact probability test). No other comparison reached statistical significance. The overall improvement rate (43%) lies between those previously cited in the opening paragraphs.^{1,5,11-16}

Although an oversimplification, the present findings, in respect to the developmental histories and the response to treatment, suggest at least three aetiologically discrete types of premature ejaculation. This view gains added support from the outcome of therapy, which was different in the three types.

"Type 1" seemed predominantly constitutionally determined. Precipitous ejaculation in these cases was the habitual response present since attaining sexual maturity in adolescence. It seemed to possess some of the characteristics of a brisk autonomic reflex based on instability or lability of that system. In support of this contention, many of these patients showed evidence of exaggerated somatic manifestations of anxiety involving many physiologic systems. Excessive sweating, tachycardia, tremor, muscular hypertonus and various urinary difficulties could be easily induced by appropriate stress. "Type 1" premature ejaculators showed psychological evidence of a neurotic diathesis, although, as a group, being just within the upper limit of normal in respect of "neuroticism" and "anxiety" on the N.S.Q., they scored significantly higher than the other types and showed many psychological symptoms consistent with psychoneurosis. It may be that in these patients the high anxiety factor by minimizing or preventing the habituation process was playing a large part in the maintenance and consolidation of the ejaculatory disorder. "Type 1" premature ejaculation probably fits best the protocol of the psychosomatic model, in which a constitutionally predisposed physiologic system may be influenced adversely by the psychological status of the organism, the response to stress in the present case being a functional disorder of ejaculation, which may become "stabilized" as premature over months or years. "Type 1" premature ejaculators correspond closely to Schapiro's "Type B" patients who had an abnormally high sexual tension and showed other evidence of a high sex drive, "a hypertonus of the entire sex apparatus."⁵ He believed that genetic factors played a significant role in etiology. "Type 1" premature ejaculators had the worst response to treatment. There seemed two likely explanations for this: the time factor (by the time most of these patients had reached a treatment situation the condition had been established for at least a decade) and the time of development and consolidation (adolescence). This formative period is apparently when habits and behavior patterns are likely to become fixed as permanent features. Dysfunctions consolidated during this time may be more resistant to change than those that develop later. Whether or not patients who began therapy in early adolescence could be trained, like enuretics, to learn the psychologically adaptive response of delaying orgasm and ejaculation to achieve full satisfaction is an interesting speculation. It awaits examination.

"Type 2" premature ejaculation in the present study is comparable to "uncomplicated premature ejaculation" as described by Tutbill.⁴ (Schapiro's classification does not recognize as a discrete clinical entity patients comparable to "Type 2" disorders). Both the present author and Tutbill indict anxiety as being a significant cause and indicate a generally favorable outcome to treatment. It is highly likely that with or without treatment, most of these patients, who are frequently sexually ignorant, inhibited and relatively inexperienced or chaste, would (providing sex was basically acceptable to both partners) with time and experimentation make a satisfactory adjustment. The condition in most cases seems to be an acute anxiety neurosis. A failure to respond to fairly simple measures such as relaxation training, reassurance and education, may suggest complicating factors (a coexisting personality disorder or severe generalized neurotic proclivities of one or both partners). Treatment in such cases

may require a more and uncertain even if therapy

"Type 3" premature who, usually older than thenia and sexual hypogiven way to premature sufficiency. In the presentation, the most consistent in sexual responsiveness proficiency. Premature sexual apathy and ultimate

Schapiro's treatment subjects and was basically "drive," having the same drugs. It consisted of a tonics, testosterone and intense stimulation, to ment rate was 65 per cent series. This difference through it may be a real therapy in Schapiro's series

The short-term prognosis set impotence in young the presence of normal tively.²⁰ It seems that tence are caused by the person at different times sumably depends mainly time and the nature of lation seemed symptomatic portent of ultimate erection provide some of the answers

In conclusion, some of the question of premature becomes labelled as premature per se but on the speed of sexual response male's self-image of himself pointed out how feelings (unwarranted in reality fails to live up to a population can sustain erection necessary to establish of the patient. Simple formation, may convince adequacy. In unequivocal

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may require a more analytical approach. In the author's view, the outcome is uncertain even if therapy is prolonged.¹⁸

"Type 3" premature ejaculation approximates Schapiro's "Type A" subjects, who, usually older than his "Type B," presented a picture of "general neurasthenia and sexual hypotonus."⁵ In these cases, normal potency had gradually given way to premature ejaculation, often in association with erectional insufficiency. In the present "Type 3" and Schapiro's "Type A" premature ejaculation, the most consistent and impressive finding was the progressive decline in sexual responsiveness with a concomitant falling off in erections and coital proficiency. Premature ejaculation in these patients often seemed a portent of sexual apathy and ultimately complete impotence.

Schapiro's treatment was essentially opposite of that for his "Type B" subjects and was basically designed to induce a resurgence of a "flagging sex drive," having the same aim as the present author, who, however, omitted drugs. It consisted of a judicious combination of prolonged sexual rest, nerve tonics, testosterone and general roborant measures, including more varied and intense stimulation, to restore mental and physical vigor. Schapiro's improvement rate was 65 per cent compared with that of 46 per cent for the present series. This difference may possibly be due to different criteria of selection, although it may be a real difference, the consequence of long and more intense therapy in Schapiro's series.

The short-term prognosis of "Types 2 and 3" approximates that of acute onset impotence in young males, impotentia ejaculandi (failure to ejaculate in the presence of normal desire and erection) and insidious impotence, respectively.²⁰ It seems that "Type 2" premature ejaculation and acute onset impotence are caused by the same sort of factors. Both may occur in the same person at different times. Whether one condition or the other manifests presumably depends mainly upon the psycho-physical status of the male at the time and the nature of the stimulation provided. "Type 3" premature ejaculation seemed symptomatic of a general decline in sexual responsiveness: a portent of ultimate erectional incapacity. A long-term follow-up study will provide some of the answers to these queries.

In conclusion, some general comments which might be helpful in clarifying the question of premature ejaculation seem justified. Whether or not a male becomes labelled as premature may depend not so much on his speed of ejaculation per se but on the attitudes and beliefs of the female partner, her own speed of sexual response, her degree of satisfaction or frustration, and the male's self-image of his sexual prowess. In this respect, Kinsey et. al.⁶ have pointed out how feelings of sexual inadequacy and a belief of prematurity (unwarranted in reality) may develop and become fixed, because the male fails to live up to a popular sexual stereotype (usually a sexual superman) that men can sustain erections and continue coitus for hours on end. It is clearly necessary to establish whether the condition exists in fact or only in the mind of the patient. Simple explanation and reassurance, reinforced by factual information, may convince an apprehensive male of his sexual normalcy and adequacy. In unequivocal (clinical) premature ejaculation, the ubiquity of a

common presenting symptom is apparent. Although the present series is small, the findings suggest the likelihood of at least three etiologically discrete types of disorder. These require somewhat different therapies and have different prognoses.

SUMMARY

Thirty male subjects, who presented in a psychiatric outpatient department with a primary complaint of premature ejaculation, were studied prospectively to provide clinical and psychological data.

Clinically, three main types of premature ejaculation were recognized. "Type 1" was habitual premature ejaculation with strong erections, present constantly since adolescence. "Type 2" was acute onset premature ejaculation generally with erectional insufficiency, occurring in young males, usually in response to a specific psychological or psycho-physical stress. "Type 3" was insidious onset premature ejaculation generally with erectional insufficiency and other evidence of declining sexual responsiveness occurring in generally older males.

Treatment, which was practically oriented, aimed to remove psychological factors that the therapist judged might be contributing to the prematurity. It was applied for a minimum of one year (20 sessions) and consisted in the individual case of an optimum permutation of training in relaxation, sexual education, provision of optimum sexual stimulation, Semans' maneuver,⁹ and psychotherapy.

At the time of assessment, 43 per cent of the patients were improved, while 57 per cent remained unchanged or were worse. "Type 1" premature ejaculation had the worst outcome of treatment and "Type 2" the best. "Type 3" occupied an intermediary position.

Although the present series is small on the basis of developmental history, clinical description and treatment response, it is suggested that there are at least three etiologically discrete types of premature ejaculation.

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outpatient department studied prospectively

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were improved, while "Type 1" premature ejaculators were the best. "Type 3" occurred

developmental history indicated that there are at least two types of premature ejaculation.

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June 5, 1996

[REDACTED]
The Ohio State University
33 West Eleventh Avenue
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Columbus, OH 43210

Dear Mr. [REDACTED]:

As you know, two complaints were made against me by patients at the Student Health Services in January, 1995. Until recently, it was my understanding that both were resolved in my favor. The most compelling evidence for this is my "Professional Staff Performance Evaluation", signed by [REDACTED] on July 1, 1995, in which my Overall Evaluation was "Excellent". Because this evaluation was done by [REDACTED] after these two complaints were resolved, I am very perplexed and upset that you now feel they are still a problem. I do not.

Because these old, resolved complaints have resurfaced, and because I do not know what you know, I want to make sure that you are aware of the outcome of the complaint evaluation process for each case. Since the University refuses to allow me to see the written conclusions about me in these cases, I will describe only what I know directly.

Case 1. Judy Brady, the Assistant Director of the Student Health Services, met with the patient and me. After several minutes of discussion, it became clear that the patient's main complaint was that I had not performed a "vinegar test" on him for the detection of genital warts. (In this test, gauze soaked with vinegar is wrapped around the patient's penis and left in place for five minutes. Then the penis is examined carefully for warts.)

The patient had, indeed, visited me specifically for an examination to detect genital warts because his girlfriend had genital warts. At that time I told him I usually did not perform a vinegar test because I felt I could see small warts better without the vinegar. So I did a thorough examination without using vinegar. The patient seemed satisfied and left my office.

But the patient's girlfriend's mother insisted that the patient return and demand a vinegar test, which he did and which resulted in the "complaint". (The vinegar test works very well on the vaginal mucosa, but not very well on the skin of a

circumcised penis. I doubt that the patient's girlfriend's mother appreciated the difference.)

The patient explained that he, himself, was not enthusiastic about getting the vinegar test, which is why he had left my office satisfied. He apologized to me for the complaint.

I told the patient that he could visit _____ for the vinegar test, if he wished. He did so. _____ later told me that the patient was ambivalent about getting the vinegar test even when visiting him, but _____ told him to do it and get it over with. The patient agreed and _____ did the vinegar test.

Within a few days after the discussion between Judy Brady, the patient, and me, Ms. Brady showed me her one-paragraph summary of the resolution. I read it and interpreted it to be in my favor, and Ms. Brady filed it. Unfortunately, I do not have a copy of the report. I hope that you have a copy of this resolution.

Case 2. This case involved a genital examination that revealed pubic molluscum contagiosum, a contagious disease that the patient had not been aware of. He questioned whether my examination had been appropriate.

A two-hour conference resulted which was attended by the patient; his male sexual partner; _____

_____ and me. After two hours, the patient asked for a decision by _____ to whether I had carried out the appropriate examination. _____ chose not to offer an opinion. _____ stated to all present that she was "99% sure" that everything I had said was truthful and that the examination was appropriate.

I have no way of knowing if _____ or _____ filed a report on this resolution.

I request that you look into both of these cases in detail, both for the manner in which they were investigated and their resolution. I invite you to review the extremely thorough method of physical examination that I use when evaluating patient's for sexually transmitted diseases. I was trained at the University of Washington in Seattle and use the methods of King Holmes, M.D., who is the Director of the Center for Sexually Transmitted Diseases there. He is also the editor of *Sexually Transmitted Diseases*, which is the most widely used textbook on this subject in the United States. I have attached a copy of the chapter in his book which covers the physical examination. I have bracketed in pen the descriptions of what I do in a routine examination for sexually transmitted diseases.

In order to compare the complaints against me with other patterns of complaints, you will need to investigate all cases of medical complaints of a sexual nature at the Student Health Services from approximately January, 1991, through the present. The reasons

for this are explained in letter dated May 26, 1996, a copy of which is attached. The investigating panel must include a medical expert on sexually transmitted diseases, a medical expert on urology, and an expert on medical epidemiology and biostatistics.

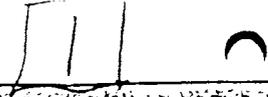
Please let me make the following point clear. This letter constitutes a formal request for a full review, by a panel of experts, of all complaints of a sexual nature made by patients at the Student Health Services from January, 1991, through the present time.

I look forward to your reply.

Sincerely,


Richard H. Strauss, M.D.
Professor of Public Health

Attachment



SEXUALLY
TRANSMITTED
DISEASES

SECOND EDITION

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SEXUALLY TRANSMITTED DISEASES

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Chapter 10

Anatomy and physical examination of the male genital tract

Daniel O. Graney
John N. Krieger

INTRODUCTION

Any area of the body may be involved in sexually transmitted disease syndromes or in the differential diagnosis of these conditions. Clearly there is no single, optimal method for conducting the history and physical examination. The critical areas of interest are determined by the history, other physical findings, and conditions considered in the differential diagnosis. There are as many correct ways of eliciting historical data and physical findings as there are clinicians. Similarly, there are many critical anatomical points that may be important in some contexts yet irrelevant in others. Thus, this chapter reflects our bias and represents an attempt to succinctly present one approach to "the routine examination." Pertinent genitourinary tract anatomy will be presented in the context of this examination. This approach is selective in the extreme, but it is based on our own clinical experience in developing an efficient method for evaluating a large number of patients in a timely manner.

Most often, the standard examination of a patient in our clinic proceeds according to an orderly sequence. The pertinent portions of the examination usually follow the outline in Table 10-1. Proceeding in this fashion has two advantages. First, there is an orderly sequence to the examination that limits the oppor-

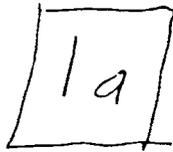
tunity for errors of omission in a busy clinical situation. Second, there is a minimal need for the patient to move. Ordinarily, we initiate the examination by having the patient sit on the examining table. If necessary, head and neck examination and percussion and auscultation of the chest may be done in this position. Next, the patient is asked to lie supine. Cardiovascular examination may be conducted in this position, if indicated, and attention is directed to the abdominal examination. The patient is then asked to stand for examination of the groin and genitalia. Finally, the patient is asked to turn and bend over, placing his elbows on the examining table, for the rectal and prostate examination. In sum, there is minimal need for the patient to move from position to position if the examination is done in this order.

The remainder of this chapter is organized to follow this suggested pattern of evaluation. The relevant considerations in routine examination of the male are presented for each section of the physical examination, and critical anatomical principles are considered for that area. Throughout, we emphasize a practical approach and minimize use of Latin terms. This means that we present the anatomy according to our own opinions, recognizing that some of these opinions are controversial and that other anatomists and/or clinicians may hold alternative, equally valid, viewpoints.

There are two major differences in anatomy and examination between male and female patients. First, in the male we are talking about genitourinary tract examination. In the female there is a urinary tract and a separate genital tract. These two functions are combined in the male lower genitourinary tract, in which the urethra serves as a common conduit for the excretory functions of the urinary tract and for the reproductive functions of delivery of semen. The second major difference is that the critical reproductive organs in the male are all easily palpable. In contrast, the reproductive organs in the female are located in the pelvis and therefore may be examined less readily than the comparable structures in the male. The clinical implication is that examination of the male lower urinary tract and the entire male genital tract is readily accomplished and is straightforward in most patients.

Table 10-1. Routine STD Examination of the Male

General appearance
Skin
Abdominal examination
Groin
Hernia
Adenopathy
Genitalia
Penis
Prepuce
Urethral meatus
Shaft
Scrotum
Testis
Vas
Epididymis
Rectal examination
Tone
Fissure, hemorrhoids, or mass lesions
Prostate examination
Laboratory studies
Stool guaiac
Urethral smear
Urinalysis
Other



EXAMINATION OF THE ABDOMEN AND GROIN

ABDOMEN

Complete details of the abdominal examination are beyond the scope of this chapter. However, brief mention is necessary of the pelvic organs, specifically the urinary bladder. This may be distended in patients with bladder outflow obstruction caused by an enlarged prostate or urethral stricture, and occasionally in patients with neurological dysfunction, as may occur with herpetic infections. The normal bladder is not palpable or percussible when it is empty or nearly empty because of its location in the pelvis. As the volume increases to approximately 125 to 150 ml, the dome of the bladder rises out of the pelvis into the lower abdomen and may project above the symphysis pubis. As it continues to fill, the bladder rises progressively toward the umbilicus. When the bladder contains 400 ml or more, it may be identifiable by observation as a bulge in the lower abdomen. Percussion over a distended bladder may cause the patient to experience a desire to void and may result in a change of the normal resonance of the lower abdomen on percussion to a dull note. The distended bladder may be palpated as a firm, round, and tender mass in the lower abdomen.

GROIN

The groin, or inguinal region, should be examined for the presence of adenopathy while the patient is lying supine on the examining table. The patient is then asked to stand and the inguinal area is again examined for the presence of hernia by direct palpation of the area and again by insertion of the index finger through the neck of the scrotum following the spermatic cord. Both examinations are done with the patient standing quietly and again while he is straining.

palpated for evidence of induration. Induration is often secondary to infection, stricture (or scarring), or, rarely, tumor, abscess, or foreign body inserted by the patient. At this point, the urethra should be "milked" or stripped, beginning at the bulbous urethra (located at the perineal body, behind the scrotum in the midline) and proceeding to the meatus. This is necessary for evaluation for urethritis and may result in an expression of discharge at the meatus.

GENITALIA

PENIS

Examination

It is critical that the clinic staff instruct patients to refrain from voiding, if at all possible, prior to examination because signs of urethritis may not be apparent if the patient has recently voided.

In fact, in symptomatic patients who do not have objective evidence of urethritis on examination or on the urethral smear, it is our practice to repeat the examination prior to the first urination of the day. Initially, attention is directed to examination of the skin. Use of a good light source and a hand lens is strongly recommended. In patients undergoing evaluation for condylomata or sexual contacts of patients with condylomata, including women with dysplasia or carcinoma of the cervix, an acid "wash" is applied after the initial evaluation. This is done by soaking gauze pads in 3 to 5% acetic acid. The gauze is then applied to the skin of the scrotum and penis and left in place for 5 min prior to repeating the examination. This examination should be carried out with use of magnification looking for "flat warts."

Attention is then directed to examination of the penis. In uncircumcised patients, the foreskin should be retracted to rule out phimosis with an obstructing small opening. This maneuver may reveal balanitis, condylomata, and, occasionally, tumor, as the cause of a foul discharge. The glans and inner surface of the foreskin should be inspected to rule out presence of ulcers, vesicles, or warts. The location of the meatus is determined and the urethra is examined for presence of spontaneous discharge. If the location of the urethral meatus is abnormal, it can usually be found by following the midline along the undersurface of the penis. This is the most common location for an abnormal orifice and is termed *hypospadias*. Hypospadias is associated with a prepuce that does not completely encircle the glans but is incomplete on the lower surface. This is commonly termed a "hooded prepuce." Patients with more severe degrees of hypospadias, in which the urethral opening is located at the base of the penis or on the perineum, often have bifid, or split, scrotums. Rarely, the location of the urethral meatus may be on the upper surface of the phallus, a condition termed *epispadias*. In either hypospadias or epispadias, there is apt to be chordee, or an abnormal curvature of the phallus. Partial or complete duplication of the urethra may be noted. Commonly, patients with urethral duplications who present with urethritis have involvement of the accessory urethral meatus. The urethral meatus is examined by pinching the glans between the thumb and the forefinger at the 6 and 12 o'clock positions. This is important to exclude presence of meatal stenosis or intraurethral lesions, such as condylomata.

The shaft of the penis is palpated, looking for firm fibrous plaques (characteristic of Peyronie's disease) and the urethra is

Anatomy

Major Divisions. There are two parts of the penis, the base, which is attached to the pubis, and the pendular portion. Underlying the penile skin there are three cavernous erectile bodies, the paired corpora cavernosa that are primarily concerned with erection, and the corpus spongiosum which contains the urethra. These erectile bodies are separate structures at the base of the penis but become bound by fascia along the shaft of the penis (Fig. 10-1). The corpora cavernosa are cylindrical bodies in the shaft region but taper markedly at the base where they attach to the pubic ramus and perineal membrane. The corpus spongiosum has three parts: beginning at the perineum these are the bulb of the penis, the spongy portion, and the glans at the tip of the penis.

The base and proximal portion of the penile shaft are covered by thin muscles (Fig. 10-1). The paired ischiocavernosus muscles overlie the crura and corpora cavernosa. Another pair of muscles, the bulbospongiosus, overlies the corpus spongiosum.

Urethra and Glans. The urethra is named according to the part of the penis that it is traversing. Thus, in the penis the urethra is divided into bulbous, spongy, and glandular portions. The bulbous and spongy parts of the urethra are lined by a pseudostratified columnar epithelium, except at the tip of the penis, termed the *fossa navicularis*, which is lined by stratified squamous epithelium. The epithelium contains small acini of mucous cells (glands of Littre) as well as mucosal and submucosal glands termed *urethral* or *periurethral glands* (Figs. 10-2 and 10-3). These glands become infected and form abscesses.

On the superior surface of the corona of the glans penis, as well as on the undersurface near the frenulum, there are sebaceous glands, the glands of Tyson. These glands secrete a white cheesy type of material which with desquamating epithelial cells forms the smegma, a substance that accumulates between the prepuce and glans of uncircumcised men.

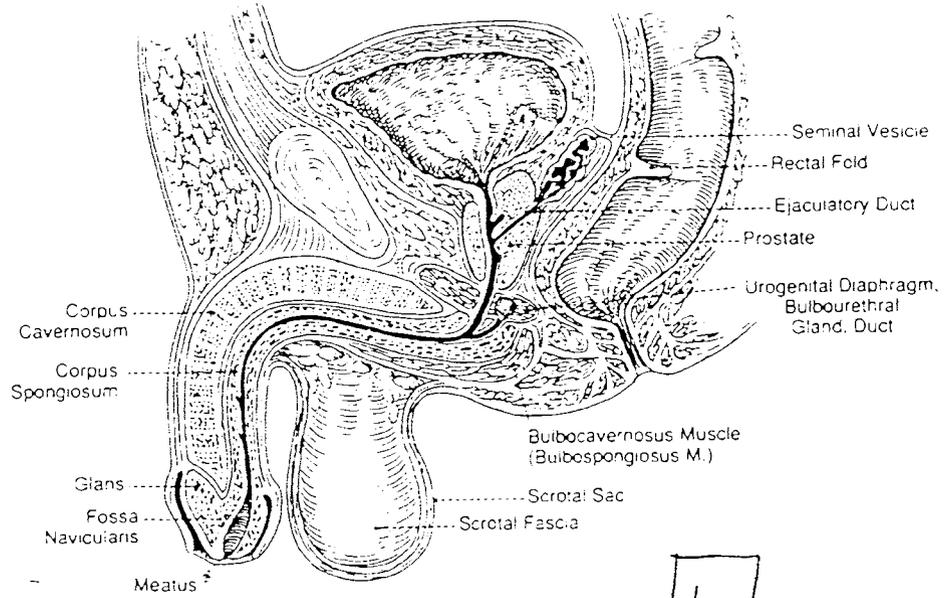
SCROTUM

Examination

Skin. The scrotum and its contents are examined next. Palpation of the scrotal skin may reveal small sebaceous cysts. These structures may be multiple and, on occasion, become quite large or develop infections. Malignant tumors of the scrotum are rare. In contrast, scrotal hemangiomas, bluish, vascular malformations, are common, and they may bleed spontaneously or following sexual activity. After the skin and subcutaneous tissues of the scrotum and perineum have been palpated, attention is directed to the intrascrotal contents.

Scrotal Compartments. The scrotum has two compartments which are divided in the midline. Each side is the mirror image of the other, and an identical examination is carried out for each

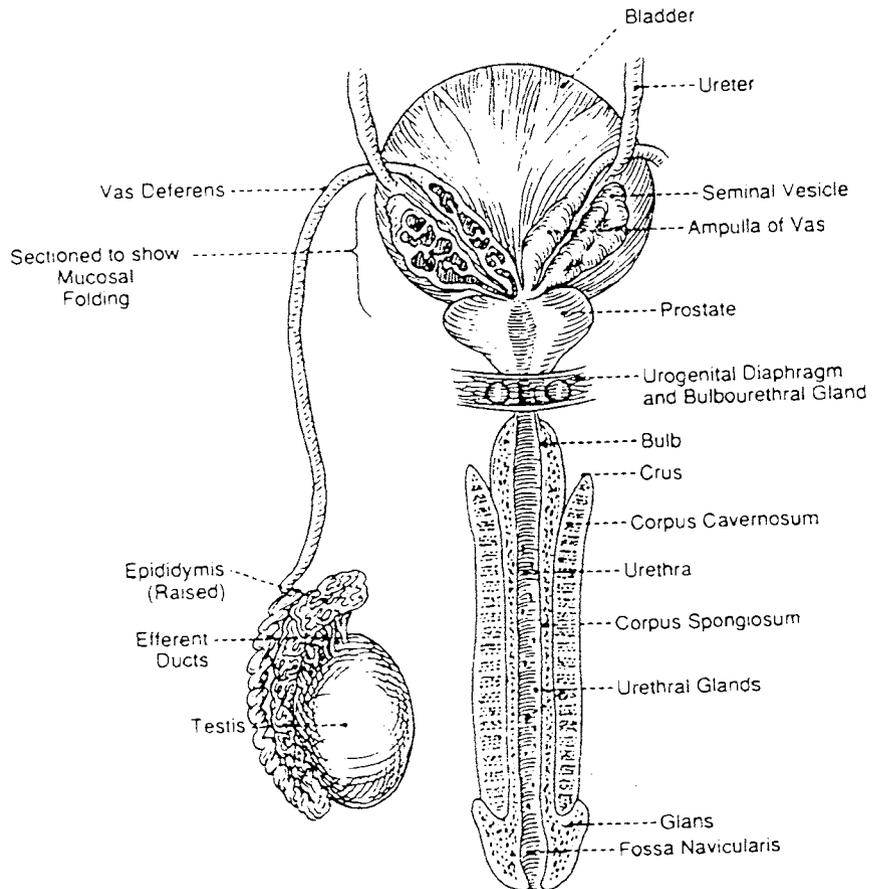
Fig. 10-1. Sagittal section of pelvis and male reproductive system.



scrotal compartment. The testis is the most anterior intrascrotal structure and must be examined carefully. The second most important structure in the scrotum is the epididymis, which lies immediately posterior to the testis.

Testis. Each testis should be palpated using two hands. Hard areas within the testicular parenchyma must be regarded as potentially malignant until proved otherwise. Testicular tumors are the most common genital urinary tract malignancy in men 20 to

Fig. 10-2. Coronal section of male pelvis and urethra viewed posteriorly.



1d

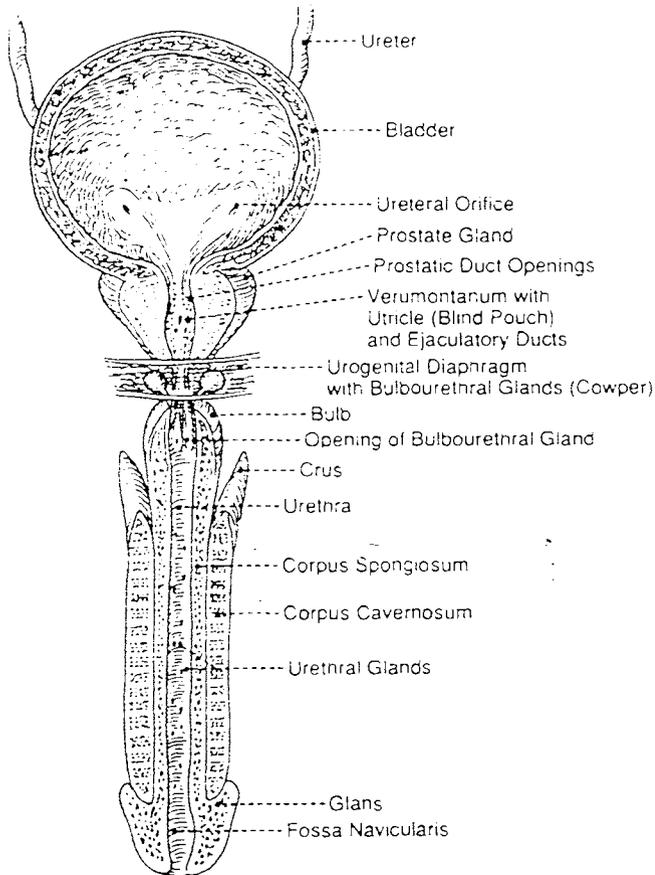


Fig. 10-3. Coronal section of male pelvis and urethra viewed anteriorly.

40 years old. Transillumination of all scrotal masses should be routine. The patient is placed in a dark room and a strong light is applied to the back of the scrotum. Light is transmitted well through benign cystic structures, such as hydroceles or spermatoceles, but not through solid mass lesions, such as testicular tumors. Tumors may be nodular in consistency but are often smooth. The testis that has been replaced by tumor or damaged by a gumma is often insensitive to pressure, and the usual sick sensation produced by firm pressure on the testis is absent. The testis may be absent from the scrotum as a result of maldescent during development, a condition known as *cryptorchidism*, or as the result of abnormal mobility within the scrotal sac and inguinal ring, a condition known as *retractile testis*. An atrophic testis is small and flabby in consistency and may be hypersensitive. This may be congenital; following treatment of an undescended testes; the result of previous infection, such as mumps orchitis; or may follow torsion or previous surgery, such as hernia repair. Although sperm production may not occur in these organs, hormone production may continue. Very small ($1.5 \times 1 \times 1$ cm), abnormally firm testes in a young adult usually are attributable to Klinefelter's syndrome, a relatively common condition present in 0.2 percent of men and is usually associated with infertility. Klinefelter's syndrome is associated with one Y and two X chromosomes. On occasion, the testis may twist within the scrotum, compromising its blood supply. This is termed *testicular torsion* and is one cause of acute scrotal pain and swelling.

Epididymis. The epididymis is a comma-shaped organ, that is usually applied closely to the posterior aspect of the testis. On occasion, however, the epididymis may be loosely applied to the testis. The epididymis should be carefully palpated for size, tenderness, and induration. Induration of the epididymis usually results from infection, as primary epididymal tumors are rare. It is often possible to feel the groove between the testis and the epididymis everywhere except superiorly, where the two structures are joined. During acute infections, the testis and epididymis are often indistinguishable, as both structures are involved in the inflammatory process. Tenderness is exquisite; swelling may be impressive and accompanied by an acute inflammatory hydrocele. In many men a small, ovoid mass, representing the appendix testis, a vestigial embryological structure, may be palpated near the groove between the upper pole of the testis and the epididymis. Occasionally, the appendix testis may twist, producing acute tenderness and swelling of the scrotum.

Spermatic Cord. The cord structures at the neck of the scrotum should be palpated between the thumb and index finger. The solid, ropelike vas is usually identified easily and may be followed to its junction with the tail of the epididymis. Other soft, stringy structures in the spermatic cord may be palpable but are usually not clearly defined. Swellings in the cord are usually cystic in nature (e.g., hydrocele or hernia) and are rarely solid (e.g., connective tissue tumor). Varicoceles represent collections of dilated veins, are usually present on the left side of the scrotum, are best demonstrated with the patient standing, and feel "like a bag of worms."

Anatomy

Testis. The testis fulfills two main functions: it produces sperm and it secretes male hormones. Production of sperm takes place in the seminiferous tubules, whereas the production of testosterone, the major male hormone, takes place in the tissue located between the tubules. Each testis contains approximately 400 to 600 seminiferous tubules. Individual tubules are up to 70 cm in length and are coiled along most of their length in order to be accommodated in a fascial compartment of the testis. These compartments are extensions of the outer fibrous capsule of the testis, the tunica albuginea. The seminiferous tubules join to form the rete testis, which is the connection to the excretory duct system. The lining of the seminiferous tubules contains two main types of cells, the developing sperm cells and the Sertoli cells, which support and presumably "nurse" the sperm cells during their development process. Sperm are continuously produced in the testis from puberty to senility following an orderly sequence of events. In the testis this process takes about 64 days. However, when they leave the testis, the sperm cells are immature and are unable to fertilize an egg.

Excretory Ducts. The excretory ducts transport sperm from the testis to the end of the male reproductive tract. The excretory ducts are composed of five elements, beginning from the testis: the efferent ducts, epididymis, vas, ejaculatory duct, and urethra.

Efferent ducts. There are approximately twelve efferent ducts, which are convoluted tubules connecting the rete testis to the epididymis. The epithelium lining the ductules contains both ciliated and nonciliated cells. Ciliary movement helps propel sperm toward the epididymis. On electron microscopy, the nonciliated cells are found to be lined by tall microvilli. Surrounding the

epithelium is a thin basal lamina, lamina propria, and smooth muscle fibers oriented circularly.

Epididymis. The epididymis receives the sperm and seminal fluid from each of the efferent ducts. The epididymis has three parts, the head, the body, and the tail. The initial segment of the epididymis is the head which fuses with the efferent ductules. The epididymis continues inferiorly along the posterior surface of the testis as the body of the epididymis (Fig. 10-2). At the inferior pole of the testis the epididymis thickens to form the tail.

Throughout its course the epididymis is lined by tall, thin columnar cells with nonmotile stereocilia. In electron micrographs the stereocilia are found to be exceptionally long filamentous microvilli. In addition, the fine structure of these cells is typical of a cell that is both secretory (abundant rough endoplasmic reticulum and Golgi cisternae) and absorptive (apical vesicles and tubules).

Within the epididymis, sperm undergo progressive maturation during their movement from the head to the tail. As sperm emerge from the testis they are infertile and relatively nonmotile. By the time they reach the tail of the epididymis, they are both motile and fertile. The average time of sperm transit through the epididymis is 12 days. The sperm and epididymal fluid together contribute about 10 percent of the ejaculate.

Vas. The vas is the continuation of the epididymal duct, with only slight modification of the epithelial surface but substantial thickening of the outer muscle coat. The thickness of the muscle coat produces the "whipcord" sensation when the vas is rolled between the thumb and forefinger during physical examination of the cord.

From the inferior pole of the testis, the vas ascends in the spermatic cord within the scrotum, until it reaches the superficial inguinal ring. After traversing the inguinal canal, the vas enters the preperitoneal space at the internal inguinal ring, where it courses inferiorly into the pelvis lying between the pelvic fascia and peritoneum. The terminal portion, or ampulla, of the vas is more dilated and fuses with the seminal vesicle to form the ejaculatory duct.

Ejaculatory duct. Traversing the substance of the posterior wall of the prostate, the ejaculatory duct opens into the prostatic urethra at the verumontanum, an oval-shaped mucosal excrescence.

RECTUM AND PELVIC ORGANS

EXAMINATION

Inspection may reveal presence of external hemorrhoids, rectal fissures, or fistulas. Internal examination is then carried out by inserting a well lubricated, gloved index finger into the anal canal. The sphincter tone is evaluated and the canal is examined for undue tenderness or induration. Presence of induration, rectal stenosis, or mass lesions may indicate the need for additional studies, such as anoscopy or proctoscopy.

With the patient bent over the examining table, the prostate and seminal vesicles are palpated through the anterior rectal wall. The normal prostate is about 4 cm in length and in width, about the size of the terminal segment of the thumb. The prostate is widest superiorly at the bladder neck. Two distinct "lobes" of the prostate are palpable, separated by a median sulcus, or indentation. Normally, the prostate gland is smooth, somewhat

mobile, and nontender. The consistency is rubbery and resembles the tip of the nose.

One major problem in the prostate examination lies in differentiating firm areas. Differential diagnosis of a firm area in the prostate includes cancer, calculi, infarction, granulomatous prostatitis, and nodular, benign hyperplasia. Even the most experienced examiner may have difficulty distinguishing among these possibilities on digital rectal examination.

Above the prostate it may be possible to feel soft, tubular seminal vesicles extending obliquely beneath the base of the bladder (Fig. 10-2). Usually, clear presence of seminal vesicles on rectal examination indicates a pathological process. Most commonly, these patients have pelvic tumors such as prostate cancer or acute infectious processes.

ANATOMY

Rectum

In the rectum, there are two to four permanent semicircular transverse folds of the mucosa, which are termed rectal valves. They neither serve as valves nor support the feces, as suggested by some investigators. These valves are readily observed during endoscopy but may be lacerated during blind instrumentation of the rectum.

Microscopically, the mucosa of the rectum is composed of columnar absorptive cells, although goblet-type mucous cells are interspersed among the absorptive cells. Invaginations of the epithelial surface form straight, tubular colonic glands equivalent to the glands of Lieberkühn seen in the small intestine.

Rectoanal junction

The rectoanal junction is not a discrete point but a region of longitudinal mucosal folds extending superiorly from a zone of mucosa that is paler and flatter (Fig. 10-4). This gives the appearance of a horizontal band with teeth, hence the term *pectinate line* (Latin *pecten*, "comb"). The mucosal ridges forming the toothlike character of the line are termed *anal folds* or *columns* (of Morgagni). At the pectinate line between the base of the anal columns, the mucosa is redundant and outpockets to form the anal crypts. The epithelium of the anus, i.e., distal to the pectinate line, is characterized by stratified squamous cells of the nonkeratinizing type.

Accessory sex glands

The male accessory sex glands include the seminal vesicles, prostate, and bulbourethral glands (Cowper's glands).

Seminal Vesicles. The seminal vesicles are paired, saccular glands with multiple foldings of their mucous membrane (Figs. 10-1 and 10-2). Embryologically they begin as tubular buds from the vas. Hence, the seminal vesicles join with the vas, forming a common ejaculatory duct.

The seminal vesicles are lined by columnar epithelial cells with abundant Golgi, rough endoplasmic reticulum, and secretory granules in the apical cytoplasm. The mucosal folds of the seminal vesicles are supported by a moderate lamina propria, containing collagen and elastic fibers. There is also a substantial muscular coat, which is important in the emission of secretions.

The seminal vesicles secrete an alkaline, slightly yellowish viscid fluid which constitutes 60 to 70 percent of the ejaculate vol-

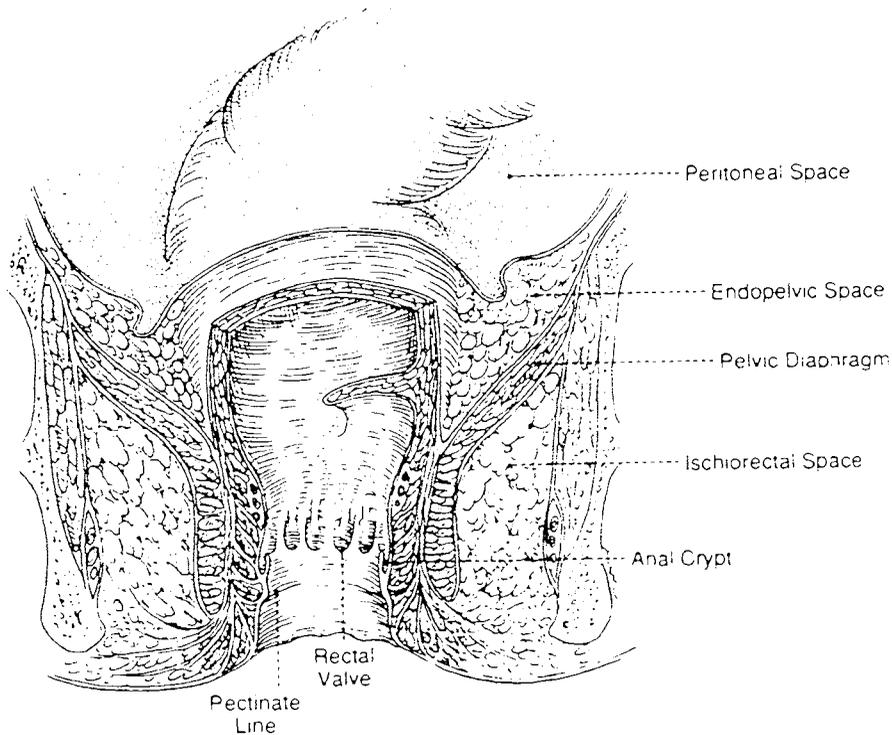


Fig. 10-4. Coronal section of male pelvis and rectoanal junction.

ume. Fractionation by "split-ejaculate" techniques shows that the semen consists of a presperm prostatic fraction, a sperm-rich fraction, and a postsperm vesicular fraction. Fructose and a variety of prostaglandins appear to be formed specifically by the seminal vesicle. Fructose is the principal energy source for sperm motility, but the role of prostaglandins in male fertility is uncertain.

Prostate. The prostate gland is located between the bladder neck and the urogenital diaphragm (Figs. 10-1, 10-2, and 10-3). The prostate completely encircles the urethra.

Zones. The prostate gland is composed of three zones of tissue: a periurethral zone, surrounding the urethra; a wedge-shaped central zone, bounded by the ejaculatory duct, urethra, and base of the bladder; and a peripheral zone, composed of all remaining glandular tissue.

The periurethral zone is composed of mucosal and submucosal glands penetrating the smooth muscle of the proximal urethra. Benign hyperplasia originates in this region and may lead to obstruction of urinary outflow from the bladder.

The central zone of the prostate is located between the urethra and ejaculatory duct. This area appears to be least susceptible to development of inflammatory, hyperplastic, or neoplastic disease.

The peripheral, or outer, zone is the portion of the prostate that is palpable on rectal examination. The peripheral zone is also the region of the prostate that is most frequently involved in carcinoma and inflammation.

Prostatic secretions. The prostate contributes approximately 30 percent of the ejaculate volume, in the form of a thin, slightly opaque fluid. The prostate gland appears to be important in protecting the male lower urogenital tract against infection, in providing enzymes for "liquefying" the semen after ejaculation, and in providing other components of the seminal fluid. Normally the pH of prostatic fluid is around 7. However, in men with well documented bacterial prostatitis, the secretions alkalinize and

may reach or exceed pH 8. Zinc, magnesium, citric acid, and acid phosphatase in the ejaculate appear to originate in the prostatic secretions.

Bulbourethral Glands (Cowper's glands). These paired, pea-sized glands are located in the urogenital diaphragm (Fig. 10-2). Their excretory ducts drain into the posterior urethra. The glands secrete a thin mucoid material during the excitatory stage of sexual response, but the bulbourethral glands contribute only a minimal amount to the ejaculate. These glands are relatively immune to hyperplastic and neoplastic disease, although they can be involved in infections.

BLOOD SUPPLY

ARTERIAL PATHWAYS (INTERNAL ILIAC ARTERY)

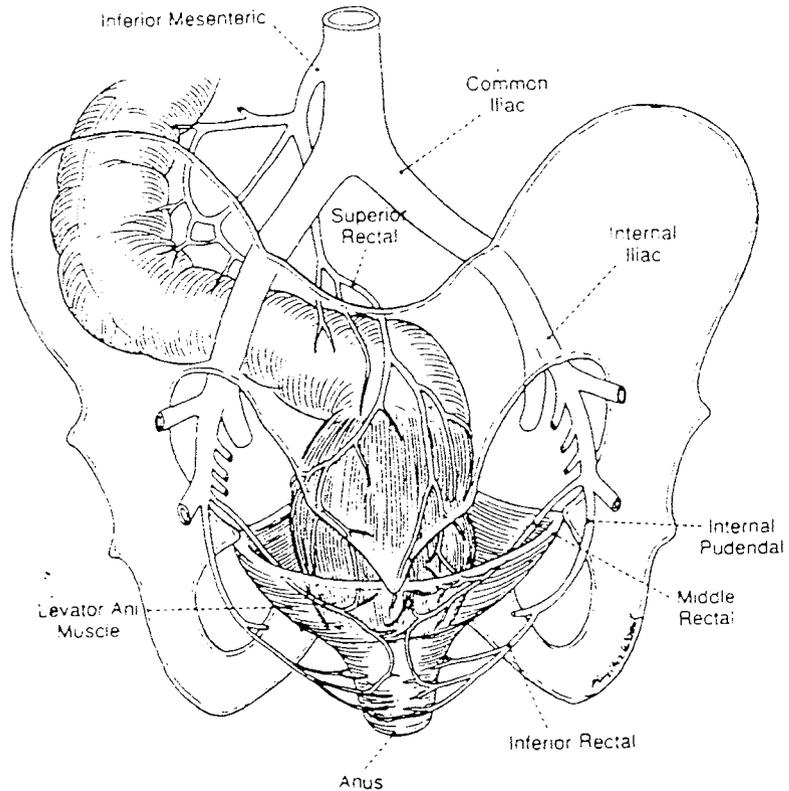
The pelvic organs in the male all receive their blood supply from the internal iliac artery. The internal iliac artery arises at the pelvic brim from the common iliac artery and immediately divides into an anterior and posterior division.

Posterior division

The posterior division of the internal iliac artery provides small branches to the pelvic sidewall and has three branches which leave the pelvis, including the pudendal arteries.

The internal pudendal artery supplies the perineum (Fig. 10-5). This includes all structures located in the ischioanal fossa and superficial and deep pouches. As it leaves the pelvis via the greater sciatic foramen, the pudendal artery gives off the inferior rectal artery and then enters the pudendal canal. The pudendal arteries have three areas of distribution: the anal canal, the perineum, and the phallus.

Fig. 10-5. Branches of the internal iliac artery and the distribution of the internal pudendal artery.



Anterior division

The anterior division of the internal iliac courses on the sidewall of the pelvis until it reaches the symphysis pubis, where it ascends the anterior abdominal wall. As it turns superiorly, the lumen of the vessel disappears and the vessel becomes a fibrous cord, the medial umbilical ligament. The internal iliac branches to form the middle rectal, superior, and inferior vesical arteries. The middle rectal artery supplies the rectum and has anastomosing branches with the superior rectal artery from the sigmoid. The superior vesicle artery supplies the fundus of the bladder whereas the inferior vesicle artery supplies the bladder neck, seminal vesicle, vas deferens, and prostate. All these vessels anastomose with their members from the opposite side.

VENOUS AND LYMPHATIC PATHWAYS

Pelvic organs

Venous Drainage. The pelvic organs have abundant venous plexuses which give rise to larger veins that parallel the arterial pattern. These veins return blood from the pelvic organs to the internal iliac vein which merges with the external iliac vessel to form the common iliac vein. This pathway joins the caval system of veins. Some blood in the perirectal region enters anastomotic channels in the mucosal plexus and ascends via the superior rectal vein to enter the portal drainage system.

Lymphatic Drainage. The lymphatic pathways from the pelvic organs follow the venous pattern. The first series of regional nodes are along the proximal parts of the internal iliac artery. From these nodes, lymphatic channels ascend to the aorta and the paraaortic lymphatic chain before entering the thoracic duct.

The sigmoid lymphatics follow the superior rectal veins to inferior mesenteric lymph nodes near the aorta.

Perineal structures

Venous Drainage. Most structures supplied by the pudendal artery are drained by veins that enter the internal pudendal vein. This vessel returns along a similar route to enter the internal iliac vein. There are two exceptions to this pattern: the anorectal region and the dorsum of the penis.

In the anorectal region blood may return via veins in the endopelvic space and eventually reach the vena cava through internal iliac tributaries or may continue superiorly to reach the superior rectal tributaries of the portal system. Increased venous pressure in this region, due to increased venous resistance in either the portal system or the caval system, can result in anorectal hemorrhoids. The anorectal submucosal venous plexus is also a pathway for the spread of infection from the perianal and rectal areas to the endopelvic space.

The second nonpudendal venous pathway from the perineum is via the dorsal vein of the penis to the prostatic venous plexus at the neck of the bladder. These veins cross the urogenital diaphragm from the perineum to enter the endopelvic space. The prostatic veins are tributaries of the internal iliac system.

Lymphatic Drainage. The lymphatic drainage of the perineum differs from its venous drainage. In essence, all the skin and superficial structures of the perineum have lymphatics which course via the medial aspect of the thigh to the superficial inguinal nodes. Thus, anal and perianal ulcers caused by syphilis, chancroid, herpes simplex virus, or lymphogranuloma venereum cause inguinal lymphadenopathy. Channels from these nodes penetrate

the fascia of the thigh at the saphenous opening to join the lymphatics from the leg. These lymphatic vessels course superiorly along the external iliac vein, then merge with paraaortic lymphatics.

An important exception is the lymphatic drainage of the testis, which does not follow the pattern described above. These lymphatics course superiorly in the spermatic cord, traverse the inguinal canal, and then ascend in the retroperitoneum with the testicular vein. In this manner the lymphatics reach the paraaortic lymph chain at the level of the renal vessels. This point is important clinically because metastases from testicular tumors do not cause inguinal adenopathy.

NERVE SUPPLY OF THE PERINEUM AND PELVIC ORGANS

The three neural components which must reach the perineal and pelvic structures are the somatic, parasympathetic, and sympathetic nerves.

SOMATIC NERVE SUPPLY

Only the perineum is supplied by somatic fibers. These arise in spinal cord segments S-2, -3, and -4 and travel via the pudendal nerve to all the skin and structures of the anal and urogenital triangles (Fig. 10-6). The pudendal nerve leaves the pelvis along with the pudendal vessels, entering the pudendal canal after giving off the inferior rectal nerves. These supply the perineal skin, external anal sphincter, and the skin of the anal canal. The pudendal nerve then divides into a perineal branch, supplying the deep and superficial pouch structures, and the dorsal nerve of the penis, supplying the skin of the penis. Branches of the perineal division supply the urogenital diaphragm, superficial perineal muscle, and skin of the scrotum.

PARASYMPATHETIC NERVE SUPPLY

The parasympathetic innervation of the pelvic organs is also derived from spinal segments S-2, -3, and -4. However, these fibers

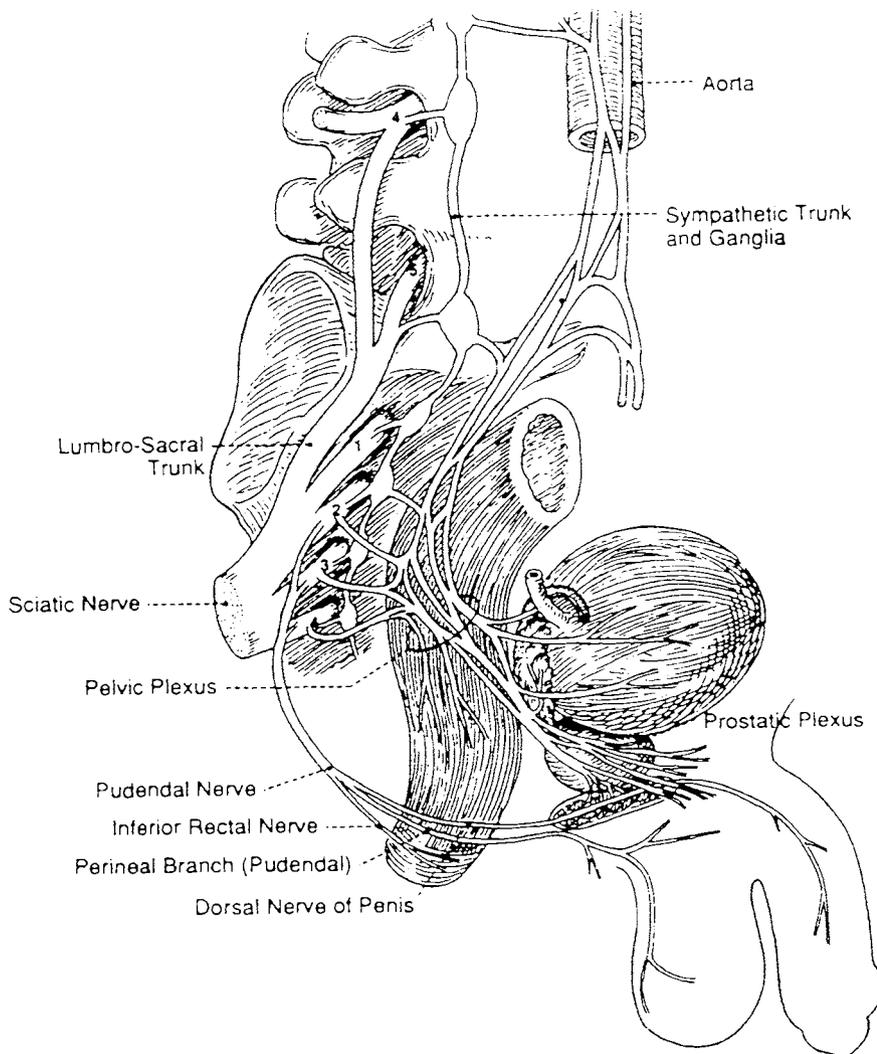


Fig. 10-6. Innervation of the pelvic viscera.

originate from neurons in the intermediolateral gray rather than the ventral gray, which is the origin for fibers in the pudendal nerve. After these fibers leave the anterior sacral foramina, they join to form the pelvic splanchnic nerve (nervi erigentes), which contributes these fibers to the plexus surrounding the viscera. This is termed the pelvic plexus. These fibers traverse the plexus without synapsing and enter the walls of the pelvic organs, rectum, bladder, and prostate, where they synapse in intramural ganglia. Short postganglionic fibers are then relayed to the muscle fibers.

SYMPATHETIC NERVE SUPPLY

Sympathetic fibers to the pelvic viscera are believed to originate in the intermediolateral gray of the spinal segments T-12 to L-2.

After joining a spinal nerve, they enter a sympathetic ganglion for that segment but do not synapse in the ganglion. The fibers descend briefly in the sympathetic chain, then course medially to enter the superior hypogastric plexus anterior to the aorta. The preganglionic fibers descend in the plexus to the inferior hypogastric plexus, which divides around the lateral sides of the pelvic organs and becomes the pelvic plexus (rectal, vesical, or prostatic). Synapses occur in the plexus or in the capsule of the organ innervated.

The pelvic plexus, therefore, is a mixture of parasympathetic and sympathetic fibers. In the region of the prostate, there is a group of fibers which course anteriorly at the upper edge of the urogenital diaphragm and supply the cavernous tissues of the penis (cavernous nerve). These fibers contain both parasympathetic and sympathetic components.

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May 26, 1996

To:
Tim Nagy, Esq.
Taft, Stittinius & Hollister
Twelfth Floor
21 East State Street
Columbus, OH 43215

From:

[REDACTED]
The Ohio State University College of Medicine
B-121 Starling-Loving Hall
320 W. 10th Ave.
Columbus, OH 43210

Dear Mr. Nagy:

Thank you for inviting me to consult with you. As you know, I am familiar with the Student Health Services because I supervised the design and execution of a study concerning genital warts in 1990 and also a survey of students about the Student Health Services in 1993. The study on genital warts utilized the data and medical records of the O.S.U. Student Health Services.

Please see the attached document.

Sincerely,

[REDACTED]

The Incidence of Medical Complaints at the
O.S.U. Student Health Services

Mr. Nagy:

The question that you raise is an interesting one, specifically: how does Dr. Strauss' record compare to that of all other physician's at the Student Health Services in terms of complaints of a sexual nature made by student-patients. Judicial outcome of the complaint process is not considered in this document.

Since the University has not given you any data on this matter, I have proceeded on the basis of interviews and by estimating certain data, as stated, in a manner which I believe to be reasonable. Following are three samples of complaint rates, followed by the outline of a simple study which could be executed by the University if it wishes to obtain accurate data for verifiable conclusions.

The result of each of the following samples is expressed as "complaints/1000 patient-visits". "Complaints" means complaints of a sexual nature made by the patient against the examining physician, brought to the attention of the Director or Assistant Director of the Student Health Services. A "patient-visit" means one visit to a physician for a medical problem that requires a physical examination of the patient's genitalia, for example, a urethral discharge or a rash in the genital area. Only visits made by men and complaints filed by men are considered.

The patient's medical problem is reflected by the diagnosis code entered by the physician on the patient's medical record, for example, "nonspecific urethritis" or "scabies". The results are expressed "per 1000 patient-visits" in order to use a common method of comparing medical data.

Sample 1. Dr. Strauss worked as the founding director of the Men's Clinic from October 1, 1993, through January 8, 1996: 27 months. He calculates that he had 1,500 patient-visits in the calendar year 1995. All of these visits required a genital examination. The daily number of visits to the Men's Clinic increased somewhat during Dr. Strauss' directorship. Thus, we estimate that Dr. Strauss had a total of 3,000 patient-visits in 27 months. During this time, 3 complaints were made against him, resulting a complaint rate of 1 complaint/1000 patient-visits.

Sample 2. _____ was the Student Health Services for the 18 months prior to assuming the directorship in 1992. _____ agreed to be interviewed.

We estimate that patients with "men's problems" were seen during this period at a rate two-thirds of that following the creation of the Men's Clinic by Dr. Strauss. This seems reasonable because the Men's Clinic appeared to attract more men for treatment at the Student Health Services than was previously the case, including men who otherwise would have sought treatment at the Columbus Health Department's Sexually Transmitted Diseases Clinic or from another physician.

We calculate that 1333 patient-visits occurred during s 18-month directorship (see footnote 1). recalls approximately 6 complaints of the nature studied here during that period. (says that this is verifiable in the Student Health Services' Quality Assurance records). Thus, there were 4.5 complaints/1000 patient visits.

Sample 3. While Dr. Strauss was the Director of the Men's Clinic, Dr. X. worked with him on a continuous, part-time basis. Dr. X. had approximately one-tenth the number of patient-visits that Dr. Strauss had. Thus, we estimate that Dr. X. had 300 patient-visits during the 27 months that Dr. Strauss was director and an additional 100 patient-visits to date, for a total of 400 patient-visits.

Dr. Strauss is aware of 2 complaints against Dr. X. that reached during this period. (It is possible that there were others, of which Dr. Strauss is not aware.) Thus, the complaint rate is 2/400 or 5 complaints/1000 patient-visits. This is about the same complaint rate as in Sample 2.

Conclusion. Dr. Strauss has a complaint rate approximately one-fifth that of all other physicians at the Student Health Services (Sample 1); and approximately one-fifth that of the other physician who worked in the Men's Clinic (Sample 2).

It appears to me that Dr. Strauss should be praised, rather than punished, for his exemplary ability to maintain an unusually low record of complaints in an area of medical practice that is at extremely high risk for complaints due to its sensitive nature. This record was maintained even though Dr. Strauss had many more patient-visits per month for sexual problems (ten times or greater) than any other physician.

Recommended Studies. The University can verify all of the above numbers if it wishes to do so.

In addition, a study design that would yield accurate results is as follows. 1) Determine the exact number of patient-visits to Dr. Strauss at the Men's Clinic. Then calculate the complaint rate as described above. 2) Find the same number of patient-visits to all other physicians for "men's problems" before and after Dr. Strauss was practicing in the Men's Clinic. Determine the number of complaints during these periods.

Calculate the complaint rate as described above. The conclusion is expected to be similar to that described above.

Footnote 1. $(3000 \text{ patient-visits}) / 27 \text{ months} \times (18 \text{ months}) \times 2/3$
= 1333 patient-visits.

(End)



Office of Human Resources

Archer House
2130 Neil Avenue
Columbus, OH 43210-1156

September 18, 1996

Mr. Randy Beck
State Medical Board of Ohio
77 South High Street, 17th Floor
Columbus, Ohio 43266-0315

Dear Mr. Beck:

Enclosed please find correspondence sent previously by your agency concerning a complaint against Dr. Richard Strauss which your agency is currently investigating. Judith Brady and I met with and answered questions for Marcia Barnett, who was investigating a complaint filed against [redacted]. During the course of that questioning, the investigator indicated that the Medical Board itself might initiate an investigation of Dr. Strauss based on information discussed during the interview. Subsequently, Ms. Brady and I received the enclosed correspondence from your agency. Ms. Brady is satisfied that she has been identified as having referred this complaint to you. However, as [redacted], I do not want to be in a position where I could compromise any privileged communications with my client. I am returning these letters and would like you to remove my name as referring this complaint.

[redacted] is the individual who should be considered to be the referring party. It was at [redacted] urging that I became involved in this matter. Had the investigator asked to speak to [redacted] on the day of her visit, it would have been [redacted] no referred the complaint and not University counsel. If there is any paperwork that [redacted] needs to complete to indicate that he referred this complaint to the Medical Board, please contact him at [redacted] and he will provide any necessary information or paperwork. Should you have any questions for me, you can reach me at [redacted] thank you in advance for your attention to this matter.

Sincerely,

Enclosure

c:

11
12
13
14
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16
17
18
19
20

Board Member
Westerville, Ohio

Carol L. Egner, M.D.
Board Member
Cincinnati, Ohio

Amund G. Gang, M.D., Ph.D.
Board Member
Boardman, Ohio

Robert S. Heidt, Sr., M.D.
Board Member
Cincinnati, Ohio

Bradley K. Sinnott, Esq.
Board Member
Columbus, Ohio

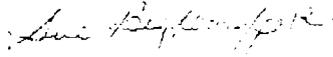
Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

Dear Ms. Brady and

Thank you for referring your concerns about Richard H. Strauss, M.D. to the State Medical Board. This information has been forwarded to the Secretary and Supervising Member of the Board for further consideration.

We appreciate the opportunity to review this matter.

Sincerely,



Sue Bigham
Public Inquiries Officer

SB/pak

77 SOUTH HIGH STREET, 17TH FLOOR • COLUMBUS, OHIO 43266-0315 • (614) 466-3934



Student Health Services

1875 Milliken Road
Columbus, OH 43210-2200
Phone 614-292-2112
FAX 614-292-7042

FAX TRANSMITTAL

DATE: August 5, 1996

TO: _____
Name

FROM: _____
Name

Address

City, State, Zip

Fax Number

Number of Pages: 2

C:\ROSE\FAX2



STATE MEDICAL BOARD OF OHIO
1896 - 1996 Celebrating One Hundred Years

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Board Member
Cincinnati, Ohio

David S. Buchan, D.P.M.
Board Member

July 31, 1996

Ms. Judith L. Brady
Assistant Director for Administration
Student Health Services

The Ohio State University
1875 Milliken Road
Columbus, Ohio 43210-2200

Dear Ms. Brady and

Charles D. Stienecker, M.D.
President
Wapakoneta, Ohio

Nora M. Noble
Vice-President
Newark, Ohio

Thomas E. Gretter, M.D.
Secretary
Cleveland, Ohio

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Board Member
Cincinnati, Ohio

Bradley K. Sinnott, Esq.
Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

July 31, 1996

Ms. Judith L. Brady
Assistant Director for Administration
Student Health Services

The Ohio State University
1875 Milliken Road
Columbus, Ohio 43210-2200

Dear Ms. Brady and

Thank you for referring your concerns about Richard H. Strauss, M.D. to the State Medical Board. This information has been forwarded to the Secretary and Supervising Member of the Board for further consideration.

We appreciate the opportunity to review this matter.

Sincerely,


Sue Bigham
Public Inquiries Officer

SB/pak



Department of Athletics

Columbus, OH
43210-1166

Telephone
Telefax

PRIVILEGED AND CONFIDENTIAL

November 7, 1994

CAMPUS

Dear

I have investigated the concerns raised by the _____ concerning athletes and the medical care system.

I have spoken with _____ and _____ concerns are based on rumors which have been generated for 10 years with no foundation. However, due to the pervasive nature of these rumors, the male athletes do not feel comfortable with Dr. Strauss as their physician.

I have spoken with Dr. Strauss concerning this issue. He is aware of the unfounded rumors which began 10 years ago among the fencers and has never been informed as to any problems concerning the rumors. In view of the present situation, Dr. Strauss has suggested that another physician, in this case _____ assume the primary role as physician for the fencers. I have spoken with _____ and he is agreeable to this.

In my discussions with both Dr. Strauss and _____, there has been no information given which would necessitate further investigation of this situation.

If you have any questions concerning this, please contact me.

Sincerely,



Office of Human Resources
Archer House
2130 Neil Ave.
Columbus, OH 43210

Mr. Randy Beck
State Medical Board of Ohio
77 South High St., 17th Floor
Columbus, Ohio 43266-0315

International Mail

- Air Mail:
 1st Class
 Printed Matter
 Parcel Post
 Parcel Post
- Surface Mail:
 1st Class
 Printed Matter
 Book Rate
 Parcel Post

Postmaster:

- Return postage
guaranteed

Domestic Mail

- First Class
 Priority
 3rd Class
 Parcel Post
 Book Rate
 Library Rate
 Express Service
 Other (specify)

Check all that
apply:

- Insurance
 Registered
 Certified
 Return Receipt

Meter Mail Account
204707-361



Columbus, OH 43201-2013

Phone 614-

FAX 614-

August 5, 1996

Dr. Richard H. Strauss
1501 Doone Road
Columbus, OH 43221

Dear Dr. Strauss:

In January 1996 you were placed on administrative leave as a result of a complaint filed by a patient who had been examined by you. In March you were notified that the Office of Student Affairs was considering nonrenewal of your 20% position with Student Health Services. This was based on a total of three complaints by students in a period of 13 months. On June 5 you and your counsel met with me and [redacted] for approximately two hours while you relayed to me your position on these complaints. At that time you also provided extensive written materials for my review.

I have considered all of the information you have provided and have received information from Judy Brady [redacted] and [redacted]. Based upon the information received during this entire process, your appointment with Student Health Services will not be renewed. This action is effective immediately. As discussed previously, your faculty appointment in the School of Public Health will continue, and should you have any questions concerning that position you should contact Dr. Ronald St. Pierre. I regret having to make this decision but based on the information provided, believe that the nonrenewal of your appointment in the Student Health Services is in the best interest of all concerned.

Sincerely,

c: Timothy Nagy

bc:



STATE MEDICAL BOARD OF OHIO

South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND/OR RECORDS

I hereby authorize and request all hospitals, medical institutions or organizations and personal physicians of _____ to release to the State Medical Board of Ohio any and all original medical records in their possession, or copies of same, pertaining to or relating to the treatment of _____.

A copy of this authorization will have all the force and effect of the original.

Signature _____

Date

Sworn to and subscribed in my presence this 24 day of OCTOBER, 1996.

Notary Public



KEVIN R. BECK
Notary Public, State of Ohio
My Commission Expires Dec. 14, 2000



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

AUTHORIZATION
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AND/OR RECORDS

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and personal physicians of _____
to release to the State Medical Board of Ohio any and all original medical records
in their possession, or copies of same, pertaining to or relating to the treatment of
_____.

A copy of this authorization will have all the force and effect of the original.

Signature

Date

Sworn to and subscribed in my presence this 24 day of October,
1996.

Notary Public



KEVIN R. BECK
Notary Public, State of Ohio
My Commission Expires Dec. 14, 2000

STATE MEDICAL BOARD
STATEMENT FORM

Report Nr. _____

Date 10 29 96 _____

I, _____ hereby make this voluntary statement

to Investigative County Board at OSU Student Union

I had gone to Biggs Hall to fill out paper work and to receive a physical. I arrived at Biggs where I filled out papers that reflected my medical history. After vitals were taken, we (the _____ team) were called in one-by-one by Dr. Straus to receive the actual physical. At the time I was called in he had asked me to take off my shirt to examine my lungs. Nothing seemed out of the ordinary until he examined my quibbles. In doing so, he turned off the light and sat Indian style in front of me. After that he asked me to take off my pants and underwear. Compared to other physicals that I have received in the past, this one had seemed a little strange. The total examination had took about 25 mins in total. During this time he had spent ~~an~~ ~~a~~ mass amount of time examining my penis and testicals. Like I said before, the examination for a hernia only took about 10 seconds. He had spent a lot more time doing this. Before the actual examination for the hernia had started, he had asked me "Do you feel a little bit ~~and~~ uncomfortable, don't you?" This had made me feel quite uncomfortable.

(Signature) _____ Address _____

Witness _____ (Cts, Ohio 4320)

STATE MEDICAL BOARD
STATEMENT FORM

Report Nr. _____

Date 10-29-96

I, _____ hereby make this voluntary statement

to _____ at _____

The examination had occurred on the first day of classes. This day was the 25th of Sept. 1994.

During the exam he had explained to me what the little bump in the testis was and why it was there. He had in also had the bump to illustrate as he was referring to _____

(Signature) _____ Address _____

Witness _____

SUPPLEMENTAL REPORT/FOLLOW-UP REPORT

COMPLAINT NO.: 96-1534A DATE OF COMPLAINT: _____

COMPLAINT INVOLVES:

<u>Strauss</u>	<u>Richard</u>	<u>H.</u>	<u>M.D.</u>
LAST NAME	FIRST	MIDDLE	DEGREE
<u>1501 Doone Road Columbus, Oh 43221</u>			
ADDRESS			
<u>(614)</u>			
TELEPHONE			

INVESTIGATIVE ACTION:

I received this letter with attachments from Dr. Strauss. However, the issues appear to be related to Complaint No. 96-1534A which is Randy Beck's case.

INVESTIGATOR: Marcia L. Barnett DATE SUBMITTED: 10/29/96

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
October 23, 1996

Ms. Marcia Barnett
State Medical Board of Ohio
77 South High St. 17th Floor
Columbus, OH 43266-0315

Dear Ms. Barnett:

I am sending you this letter to make sure that you have a copy of the enclosed documents: 1) a letter written by me on June 3, 1996; and 2) a letter written by [redacted] on November 7, 1994. These documents describe the actions take by the [redacted] in order to damage me since 1981.

I would like to advise you that the current [redacted] has been part of the O.S.U.

[redacted]. He has personally witnessed the destructive activities that [redacted] has taken against me during this period and disagrees with them entirely. He has volunteered to be interviewed by you if you wish to do so.

[redacted] can be contacted at home, telephone [redacted]. Please do not contact him at the O.S.U. Athletic Department. [redacted] recognizes that he is at risk of being fired by [redacted] if [redacted] learns that you have interviewed him.

Sincerely,



Richard H. Strauss, M.D.

RECEIVED
OCT 27 1996

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
June 3, 1996



The Ohio State University
33 West Eleventh Avenue
Suite 115
Columbus, OH 43210

Dear Mr. [REDACTED]:

I understand from correspondence with [REDACTED] that you are interested in a concern raised several years ago by the [REDACTED]

[REDACTED] looked into this concern and reported on it in a letter to [REDACTED] dated November 7, 1994. I hope that you have access to this letter. I have a copy of it because [REDACTED] directed that I receive a copy.

The key sentence in the letter is: "I have spoken with [REDACTED] and [REDACTED] concerns are based on rumors which have been generated for 10 years with no foundation." This letter clears me of any wrong-doing and closes the case.

I would like to add some information to help answer two relevant questions: 1) How did the "rumors" get started?; and 2) Why did the "rumors" persist in one specific team for 10 years (actually, 13 years)?

In 1981, [REDACTED] was a member of the [REDACTED] and was [REDACTED] who was also a member of the [REDACTED] subsequently

[REDACTED] in 1981, [REDACTED] apparently decided he did not like me, for reasons that are a mystery to me. He started the "rumors" that are referred to by [REDACTED], and told [REDACTED]

Other members of the team did, in fact, like me and disagreed with [REDACTED] and his rumor campaign.

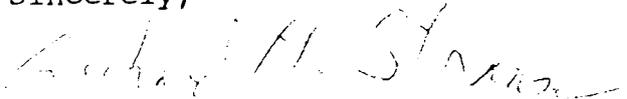
In approximately 1986, [REDACTED] advised me that the "rumors" were persisting in the [REDACTED] for reasons that were unclear to me, since [REDACTED] had left [REDACTED]

the team. and I agreed that I would make a concerted effort to avoid members of the unless they specifically asked me to treat them--which many did.

The reason for the persistence of the rumors in the became clear: a personal and continuous vendetta against me by . Approximately once a year, : took various members of the team aside and told them to "watch out" for me, citing "rumors". On one occasion, a member of the team asked hat her source of information was and she said it was

I hope this information helps you in your decision-making.

Sincerely,


Richard H. Strauss, M.D.
Professor of Public Health

100-100000-1000



Columbus, OH
43210-1166

Telephone (614)
Telefax (614)

PRIVILEGED AND CONFIDENTIAL

November 7, 1994

CAMPUS

Dear

I have investigated the concerns raised by the _____, concerning her athletes and the medical care system.

I have spoken with _____ and _____ concerns are based on rumors which have been generated for 10 years with no foundation. However, due to the pervasive nature of these rumors, the male athletes do not feel comfortable with Dr. Strauss as their physician.

I have spoken with Dr. Strauss concerning this issue. He is aware of the unfounded rumors which began 10 years ago among the fencers and has never been informed as to any problems concerning the rumors. In view of the present situation, Dr. Strauss has suggested that another physician, in this case _____ assume the primary role as physician for the fencers. I have spoken with _____ and he is agreeable to this.

In my discussions with both Dr. Strauss and _____ there has been no information given which would necessitate further investigation of this situation.

If you have any questions concerning this, please contact me.

Sincerely,

CONFIDENTIAL

State of Ohio
The State Medical Board
77 South High Street
17th Floor
Columbus, OH 43266-0315

AUTHORIZATION
FOR RELEASE OF MEDICAL INFORMATION
AND/OR RECORDS

I hereby authorize and request all hospitals, medical institutions, organizations and personal physicians of _____ to release to the State Medical Board of Ohio, any and all original medical records in their possession, or copies of same, pertaining to or relating to the treatment of _____

A copy of this authorization will have all the force and effect of the original.

Signature

11-4-96
Date

Sworn to and subscribed in my presence this 4 day of NOVEMBER,
19 96

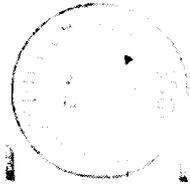


Ronald L. Thompson
Notary Public, State of Ohio
My Commission Expires 2-22-2001

Ronald L. Thompson
Notary Public

COMPLETE AND SEND DIRECTLY TO
YOU AT OUR OFFICE IF YOU
DONT RECEIVE THEM BY NEXT WEEK,
OR IF YOU DO GET THEM BUT HAVES
F/U QUESTIONS, CALL HIM DIRECT. IT
IS 46 MILES FROM MY HOUSE TO
HIS.
TAKE CARE,
RON T

Richard H. Strauss, M. D.
1501 Doone Road
Columbus, OH 43221



Ms. Marcia Barnett
State Medical Board of Ohio
77 South High St. - 1712 E. 17th
Columbus, OH 43215-0000

SEP 20 1953

03266/0325

RAND:

11.4.76

I WENT TO SEE
AT WORK TODAY. HE WAS
BUSY AND COULDN'T MAKE OUT
A STATEMENT AT THE TIME, SO
I LEFT FORMS FOR HIM TO



1906 - 1996 Celebrating One Hundred Years

Charles D. Stienecker, M.D.
President
Wapakoneta, Ohio

Nora M. Noble
Vice-President
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Thomas E. Gretter, M.D.
Secretary
Cleveland, Ohio

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Ronald C. Agresta, M.D.
Board Member
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Anant R. Bhati, M.D.
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David S. Buchan, D.P.M.
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Carol L. Egner, M.D.
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Robert S. Heidt, Sr., M.D.
Board Member
Cincinnati, Ohio

Bradley K. Sinnott, Esq.
Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

MEMORANDUM

TO: William J. Schmidt, Assistant to the Director

FROM: Marcia L. Barnett, Investigator *MB*

DATE: November 27, 1996

RE: Richard H. Strauss, M.D.
Complaint No. 96-1534A

I returned a telephone call to _____ yesterday. He was inquiring about the status of a complaint lodged against him by Dr. Strauss (96-0999A). During our discussion, _____ mentioned that Dr. Strauss had opened a "men's clinic" on 5th Avenue in Grandview.

_____ said that he has seen advertisement for the clinic in The Ohio State University student newspaper, *The Lantern*. He said that the advertisement indicates that there is more than one physician running the clinic and that the clinic offers a discount to University students. _____ believes the men's clinic may have opened around September of 1996, when the advertisements first appeared.

_____ said that he called the men's clinic and was surprised that Dr. Strauss answered the telephone. Dr. Strauss apparently did not recognize _____ voice and answered several questions about his clinic. _____ said that Dr. Strauss told him that he was the only doctor "at this time" running the men's clinic.

✓ cc: Randy Beck, Investigator

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
Home telephone: (614) 488-1094
Office telephone: (614) 293-3908

96 APR 19 PM 4:49

April 19, 1996

Dr. Thomas E. Gretter, Secretary
Ohio State Medical Board
77 South High Street
Seventeenth Floor
Columbus, OH 43266-0315

Re: Complaint of Ethical Misconduct Against

Dear Dr. Gretter:

I, Richard H. Strauss, M.D., with deep regret and great sadness, find it necessary to petition the Ohio State Medical Board to review the unethical and unprofessional behavior of my

On January 5, 1996,
engaged in fraudulent and deceptive practices by directing me to falsify a patient's medical record and by directing another of his subordinates to destroy a viable culture taken from the same patient.

These acts are contrary to the American Medical Association Principles of Medical Ethics and in direct violation of the laws governing the profession of the State of Ohio. Ohio Revised Code §4731, which governs the Practice of Medicine in Ohio, prohibits any acts which violate A.M.A. Ethics Principles as well as acts that are illegal under the criminal statutes. [Ohio Rev. Code Ann. §4731.22(B)(10), (12), (18).] Specifically, the law of the State of Ohio stipulates that it is illegal to "falsify, destroy, remove, conceal, alter, deface or mutilate any writing, data, or record." [§2913.42 (A).] This crime is a felony. In addition, A.M.A. Principle II calls for a physician to deal honestly with patients and colleagues, free of fraud and deception. I believe that the conduct set forth below is unethical and illegal.

In addition to the original acts of fraud, has violated Principles II and IV of the A.M.A. Principles of Medical Ethics and consequently Ohio Revised Code §4731.22(B)(18) through his conduct toward me. has jeopardized my professional reputation by attempting to coerce my complicity in these acts and by perpetuating unfounded accusations made by the patient with regard to my professional examination.

The facts surrounding this incident are as follows:

Dr. Thomas E. Gretter
April 19, 1996
Page 2

APR 19 1996 PM 4:19
STATE MEDICAL BOARD OF OHIO

At present, I am a tenured Professor of Public Health in the College of Medicine at The Ohio State University. In addition to my responsibilities in the School of Public Health, I am a practicing physician at The Ohio State University's Student Health Services. I have worked part-time at the Student Health Services for sixteen years, much of that time as Director of the Sports Medicine Clinic. I also have been a Team Physician for the O.S.U. Athletic Department for the past seventeen years.

During the past three years, I have been the Director of the Student Health Services' Men's Clinic, which I founded. In that clinic, I treat a large number of students--about 1,500 patient-visits in 1995.

He treats about one-tenth that number of Men's Clinic patients. He is a full-time employee at the Student Health Services.

The Men's Clinic is patterned after a gynecology clinic except that it is for men. More than half of what I diagnose and treat consists of sexually transmitted diseases. Other common problems include scrotal masses; testicular pain; dermatological problems of the pubic, genital and perineal areas; prostatitis; and sexual dysfunctions such as premature ejaculation and impotence. These are, naturally, sensitive subjects for most of my patients, and most of the patients are rather nervous when they first walk into my office. This is often their first experience with a genitourinary medical problem or examination. I have a limited time to make them comfortable enough to talk about and deal with their problem or, frequently, their multiple genitourinary problems.

On January 5, 1996, a 19 year-old Ohio State University student, henceforth referred to as "the patient", sought treatment at the Men's Clinic for symptoms consistent with a sexually transmitted disease. In fact, he was found by me to have one sexually transmitted disease and an additional urological problem.

After the conclusion of the history, physical examination, two urethral cultures, and discussion of the treatment plan for the sexually transmitted disease, we discussed the urological problem. The patient seemed uncomfortable discussing the history of the urological problem.

Then I said, "I guess we're finished". I reached for the computer on my desk and said to the patient, "I'll let you read your medical write-up". The patient looked startled and became agitated for the first time during his visit. He uttered an epithet at me and abruptly left the examination room. As the

Dr. Thomas E. Gretter
April 19, 1996
Page 3

96 APR 19 PM 4:49

patient passed the receptionist and left the waiting room, he shouted something which neither the receptionist nor I could understand.

A few minutes later, [redacted] entered my office and said that my "last patient" wanted to see his record. I told [redacted] that I would meet him and the patient immediately in [redacted].

[redacted] left and I picked up the patient's records and his two urethral cultures from my office and walked across the waiting room toward the hallway to [redacted]. I saw the patient at that time, confronting and verbally abusing the [redacted], and demanding that she purge the records of his visit from the computer system in front of her. She denied his request.

At that moment, the patient saw me and shouted "I want my records. I want the paper I signed". I said, "Come on and we'll talk," as I walked toward [redacted]. The patient ran after me and wrenched the medical records from my hands, scattering the cultures on the hallway floor. He then rapidly walked back into the reception room, approached [redacted], and again demanded that she remove all information about him from the computer system. He tore up medical records and threw various items at [redacted]. The patient then left the Men's Clinic.

Minutes later, [redacted] initial reaction was, "We should call the campus police".

Within the next few minutes I talked about this incident with [redacted] with Ms. Judy Brady, the Assistant Director of the Student Health Services; and then in private with [redacted].

[redacted] said that the patient had talked to him and had accused me of inappropriate touching, which I denied. I offered my explanation for the patient's behavior: specifically, that the patient would go to any extreme to prevent me from recording my urological findings in his medical record.

[redacted] said that the patient was from "a well-connected and influential family from [redacted]". [redacted] said that the patient's mother had called and that she was quite "reasonable". She only insisted that "Dr. Strauss not be allowed to write anything in [the patient's] record" and that "get rid of Dr. Strauss".

Dr. Thomas E. Gretter
April 19, 1996
Page 4

STATE MEDICAL BOARD
96 APR 19 PM 4:49

My write-up of every initial patient-visit is printed in detail in the patient's record because I produce it on my computer in the presence of the patient. [redacted] instructed me that I was not to write my usual report about this patient. I objected. I said that I could not even imagine what to write if it wasn't my usual, printed report. [redacted] said that he would ask Judy Brady to come in and they would determine what I should write in the patient's record.

Ms. Judy Brady joined us in [redacted]. She was carrying a plastic culture tube. She said that the culture in the petri dish (gonorrhoea) was destroyed because it lay open on the hallway floor, but the culture (chlamydia DNA probe) in her hands was still good (viable) because the plastic tube was still undamaged and the top was still on tight. What should she do with it, Ms. Brady asked. [redacted] ordered her to destroy the viable chlamydia culture.

Ms. Brady sat down. The three of us then discussed the patient's interactions with all of those involved: 1) me; 2) 3) Ms. Brady; 4) [redacted]; and 5) [redacted].

[redacted] and Ms. Brady then discussed what I should write in the patient's record--specifically, the words that would satisfy the patient's mother.

I objected, since I thought I was supposed to write a complete record in the patient's chart. [redacted] replied that if I wanted to write up my report, he would "put it in a secret place--where it would not be found if there were an investigation". I declined.

[redacted] then said that I could write whatever I wanted and keep it at home. At that point I hand-wrote and signed a sentence in the patient's record, as dictated by [redacted]: that the patient had ... "refused treatment".

Before I left the Men's Clinic the same day, I wrote an accurate record of the patient's visit and took the record home.

Shortly after assaulting [redacted], the patient visited [redacted]. [redacted] told me that he gave the patient an antibiotic for a sexually transmitted disease based on the patient's history. [redacted] said he did not do a physical examination nor take any cultures.

It is the sum of these acts--creating a false record, destroying a viable culture, and suppressing the accurate record--

Dr. Thomas E. Gretter
April 19, 1996
Page 5

-that demonstrates the intent to commit fraud in violation of the law and the ethical code of the profession.

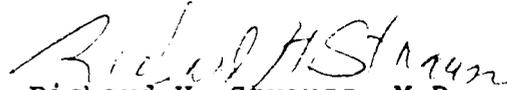
As a result of the patient's unfounded accusations against me and unethical actions prejudicial against me,

(not a physician), suspended my clinical privileges at the Men's Clinic and as Team Physician for the Athletic Department, and placed me on paid administrative leave.

conduct has been unprofessional, unethical, and in violation of Ohio law. Therefore, it should be examined immediately by the Board.

I would appreciate the Board's attention to this matter. I will make myself available to the Secretary and others who are responsible for the investigation.

Sincerely,



Richard H. Strauss, M.D.
Ohio Medical License 35-04-2299

STATE MEDICAL BOARD
OF OHIO
96 APR 19 PM 4:49

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: Kevin R. Beck, Investigator

FROM: John W. Rohal, Assistant Director

DATE: August 22, 1996

RE: Richard H. Strauss, MD
B101 Starling-Loving Hall
OSU Hospital
Columbus, OH 43210
Complaint # 96-1534 A&B

Attached is a copy of a complaint which alleges a hospital action based upon inappropriate physical examinations of male patients.

Conduct a further inquiry into the problem

JWR:jh

cc: C. Jay Hunter, Area Supervisor

8/1/96

STATE MEDICAL BOARD OF OHIO
COMPLAINT TRACKING FORM

Complaint number(s) 96-1534 A+B

COMPLAINT INVOLVES:

NAME Strauss, Richard H MD
last first (MD, DO, DPM etc)

Address B101 Starling-Loving Hall

Ohio State University Hospital

City Columbus State OH Zip 43210

Ohio license number 35-042299

COMPLAINT TYPE SEX

Prior Complaint Numbers N/A

ON CITE LIST? Enf. Coordinator N/A

CROSS REFERENCES:

Ohio State University Hospital 96-1534 B Priors: 96-641 B + numerous closed (see list)
Name complaint #

Name complaint #

Name complaint #

Name complaint #

COMMENTS:

pro hrs.

EC 8/20/96 7. RICHARD H. STRAUSS, MD - INVESTIGATION

Secretary

Supervising Member

Investigation

Other agency

Office Conf.

Vol. Surrender

Staff Review

Formal Action

Prosecutor

No further action

Other

Date/initials 8/1/96 [initials]

07/31/96

MDMAST

09:08:46

(last) (first) (title)
1) Name: STRAUSS RICHARD HARRY

Filenum 35-042299

Addr1: B 10: STARLING-LOVING HALL

Addr2: OHIO STATE UNIVERSITY HOSPITAL

City: COLUMBUS St: OH

County: 25 FRANKLIN Zip: 43210-0000

Addr1:

Addr2:

City: St:

County: 00 Unknown Zip: 00000-0000

3) SRS Status: 3A ACTIVE LIC
Issue Date: 06/20/96
Expiration Date: 09/30/98

2) Sex: M Birth: 07/30/38 Deceased: 00/00/00

SSN: Redacted City: CHICAGO

St: IL Country:

How Issued: N END NATL BDS Date: 07/11/78

Specialty: IM INTERNAL MEDICINE

Cert. Mailed Date: 00/00/00 MEEP: 00/00/00

Graduation: 06/12/64 School: 01602 UN OF CHICAGO, PRITZKER SM, CHICAGO

This record has No Formal-Action(s)!!! PRESS<Return>

07/3 /96

SEARCH

29:28:09

1 96:534A STRAUSS, RICHARD H
Ty: SEXUAL IMPROPRIETIES

By: BRADY, JUDY
Stat: COMPLAINT RECEIVED

Inv:

2 96:534B OSJ HOSPITALS
Ty: FAILURE TO REPORT

By: OSMB/RAY BUMGARNER - Inv.
Stat: COMPLAINT RECEIVED

-
-
-
-
-

07/31/96

STATE OF OHIO MEDICAL BOARD
COMPLAINT TRACKING

29.28.48

NAME: OSU HOSPITALS	LICENSE:	LICENSE NO: 020200
COMPLAINT TYPE: FTR-FAILURE TO REPORT		TYPE DATE: 07/31/96
COMPLAINT STATUS: INI-COMPLAINT RECEIVED		STATUS DATE: 07/15/96
SUPERVISE BD MEM: RJA-RAYMOND ALBERT		
BOARD SECRETARY: TEG-THOMAS E. GRETTER, MD		
INVESTIGATOR: -		
ENFORCEMENT CO: -		
COMPLAINT NUMBER: 9615348	NOTE:	

MDMAST INFORMATION	
LIC NO MISSING or INCORRECT	SS #:
	DOB YR: LIC DTE:
	LEGAL STAT:
	STATUS:

Press PF2 For Help

gwr

COMPLAINT FORM

RECEIVED

By: Marcia L. Barnett *MB*
Time & Date: 1:00 p.m. July 15, 1996
Telephone: ___ Personal Appearance: xx

COMPLAINANT

Name: Judith L. Brady, Assistant Director for Administration
Student Health Services

Address: The Ohio State University
Student Health Services
1875 Milliken Road
Columbus, Ohio 43210-2200

Phone: (614) 292-0110 (Ms. Brady)

COMPLAINT INVOLVES

Name: Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
(614) 488-1094 (home)
(614) 293-3908 (office)

COMPLAINT

During the course of investigating Complaint No. 96-0999A, involving _____, I learned that Dr. Strauss, the complainant, is under "investigation" by Ohio State University officials for allegedly performing inappropriate physical examinations of male students at the Student Health Services, Men's Clinic.

It was alleged by Ms. Brady and _____ that Dr. Strauss filed a complaint with the Medical Board against his supervisor, _____, who is the _____ in an attempt to conceal the real issue. Ms. Brady and _____ feel that were no violations involving _____

Dr. Strauss was suspended from "clinical" practice at the OSU Student Health Services as a result of a complaint made by a male student who he examined on January 5, 1996.

According to Ms. Brady and [redacted] there were several other incidents of a sexual nature involving Dr. Strauss and male patients. A "Due Process" Hearing was held in June of 1996 to examine the details of the January 1996 incident and other previous incidents.

The decision, which has not yet been rendered, will affect the renewal of Dr. Strauss' appointment to Student Health Services, where he has worked 20% of his time. Dr. Strauss is a full-time, tenured faculty member in the School of Health.

Dr. Strauss is alleged to have inappropriately touched male patients, and to have used obscene language to describe human anatomy and functions, during physical examinations. It is also alleged that Dr. Strauss asked his patients specific and inappropriate questions about their sexual relationships.

[redacted] said that Dr. Strauss was also performing physical examinations of male athletes for some of the University's athletic teams through a contract he had with the Athletic Department. [redacted] believed that Dr. Strauss was asked not to provide any further services to the Athletic Department as a result of the Student Health Services action.

Ms. Brady and [redacted] suspected that Dr. Strauss was a homosexual. However, they had no evidence to that effect and Dr. Strauss had not, to their knowledge, informed anyone on staff that he was homosexual.

[redacted] said that the University has not, at this time, filed a formal complaint with the Medical Board regarding the allegations against Dr. Strauss. She said that the University might do so after an official decision is rendered concerning Dr. Strauss' appointment to Student Health Services. She further asked that the Medical Board strictly maintain the confidentiality of their internal inquiry concerning Dr. Strauss.



STATE MEDICAL BOARD OF OHIO

Charles D. Stienecker, M.D.
President
Wapakoneta, Ohio

Nora M. Noble
Vice-President
Newark, Ohio

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Cleveland, Ohio

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Board Member
Columbus, Ohio

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Board Member
Westerville, Ohio

July 31, 1996

Ms. Judith L. Brady
Assistant Director for Administration
Student Health Services

The Ohio State University
1875 Milliken Road
Columbus, Ohio 43210-2200

Dear Ms. Brady and

Thank you for referring your concerns about Richard H. Strauss, M.D. to the State Medical Board. This information has been forwarded to the Secretary and Supervising Member of the Board for further consideration.

We appreciate the opportunity to review this matter.

Sincerely,

Sue Bigham
Public Inquiries Officer

SB/pak

MEMORANDUM

TO: Thomas E. Gretter, MD, Secretary
Raymond J. Albert, Supervising Member
FROM: Diann K. Thompson, Chief Enforcement Coordinator
DATE: January 6, 1997
RE: OSU Hospital
Complaint #96-1534B

dket 1/6/97
Close T23 1/16/97
ELP 1/24/97

This file was forwarded to me for assignment for citation in association with Complaint #96-1534A against Dr. Richard H. Strauss. **Since it appears that the "B" complaint was opened in error, I recommend that it be closed.**

Dr. Strauss worked part-time at the Men's Clinic, Student Health Center at OSU; they received allegations of sexual misconduct against him; these were investigated and ultimately led to his dismissal. The Student Health Center is cooperating with the Board's investigator, Mr. Beck, in identifying victims and telling him who else should be interviewed. This led Mr. Beck to the Athletic Department at OSU, which also had difficulties with Dr. Strauss. The Athletic Department is also cooperating with Mr. Beck in identifying further victims.

There is nothing in the file to indicate that Dr. Strauss was employed by, or had privileges at, or was in any way associated with, OSU Hospitals. The Student Health Center is not an extension of the Hospital; it is under the administration of the Department of Student Affairs (or similar entity). Therefore, there is no reason to have a complaint open against OSU Hospitals in this matter. Further, it appears from the review of the file that the Student Health Center did the appropriate thing in investigating and terminating the physician and is also cooperating with this Board. Therefore, there appears to be no reason to open a complaint against that entity.

The complaint against Dr. Strauss (the "A" complaint) is assigned and should remain open.

Please advise.

EC 1/28/97 34. O.S.U. HOSPITAL - CLOSE

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: K. Randy Beck, Investigator

FROM: John W. Rohal, Assistant Director



DATE: January 30, 1997

RE: OSU Hospitals
Complaint # 96-1534 B

After further review it has been decided to close this portion of this complaint.

JWR:jh

cc: C. Jay Hunter, Area Supervisor

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: Diann K. Thompson, Chief Enforcement Coordinator

FROM: John W. Rohal, Assistant Director 

DATE: December 18, 1996

RE: Richard H. Strauss, M.D.
O.S.U. Hospitals
Complaint # 96-1534 A&B

Attached are the enforcement files of Doctor Strauss and O.S.U. Hospital which are forwarded for assignment to Cite.

JWR:jh

cc: K. Randy Beck, Investigator
C. Jay Hunter, Area Supervisor

STATE MEDICAL BOARD OF OHIO
REPORT REVIEW FORM

COMPLAINT NO. 96 1534 A/B

COMPLAINT TYPE:
Sex / FTR

COMPLAINT INVOLVES:

Richard H. Strauss
OSU Hosp.

COMMENTS

To Enforcement to possible
disclosure a cite. 12/15/96

12/15/96 to Enforcement for cite 48

EC 12/11/96 48. RICHARD H. STRAUSS, MD - CITE

IF OFFICE CONFERENCE - REASON:

TO ACCOMPLISH:

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: Kevin R. Beck, Investigator

FROM: John W. Rohal, Assistant Director 

DATE: August 22, 1996

RE: Richard H. Strauss, MD
B101 Starling-Loving Hall
OSU Hospital
Columbus, OH 43210
Complaint # 96-1534 A&B

Attached is a copy of a complaint which alleges a hospital action based upon inappropriate physical examinations of male patients.

Conduct a further inquiry into the problem

JWR:jh

cc: C. Jay Hunter, Area Supervisor

STATE MEDICAL BOARD OF OHIO
COMPLAINT TRACKING FORM

Complaint number(s) 96-1534 A+B

COMPLAINT INVOLVES:

Secretary

Supervising
Member

NAME Strauss, Richard H MD
last first (MD, DO, DPM etc)

Investigation

Address B101 Starling-Loving Hall

Other agency

Ohio State University Hospital

Office Conf.

City Columbus State OH Zip 43210

Vol. Surrender

Ohio license number 35-042299

Staff Review

COMPLAINT TYPE SEX

Formal Action

Prior Complaint Numbers N/A

Prosecutor

ON CITE LIST? Enf. Coordinator N/A

No further action

Other

Date/initials

CROSS REFERENCES:

Ohio State University Hospital 96-1534 B Priors: 96-641 B * numerous closed (see list)
Name complaint #

Name complaint #

Name complaint #

Name complaint #

COMMENTS:

**ENFORCEMENT
Medical Board**

- Issues
- Search
- Add New
- Tickler
- Work Queue
- Work Queue Sort
- List Active
- Follow-Up List
- Enforcements
- Search
- Add New
- Tickler
- Work Queue
- Work Queue Sort
- List Active
- Follow-Up List

Legacy

Issue View Screen

Case	1996-96153402	Date Received	07/15/1996	Audit	
Status	CLOSED	How Received	Data Conversion	Documents	
Respondent ID	3983947	Receiving Board	MED	Entry Items	
Respondent	Ohio State University Medical Center	Receiving	MED - Issue Worker	Notes	
Updates	Unavailable - Converted to eLicense 2.0	Department		Enforcement	
Initiator ID	3976827	Received By	LEGACY DATA		
Initiator	Executive Staff	Date Reviewed	07/31/1996		
		Category	MED - Data Conversion		
		Priority	Undesignated		
		Docket/AG Number			
		Alleged Issues			
		FTR - Failure to report			

Complaint:

Other Participants

No additional participants found

Resolution

Department	MED - Issue Worker	Found Issues	
Worker	Worker	Resolution Type	MED-INN-Investigated-Disposed
Date Closed	01/28/1997	Last Worker:	

Resolution:

Action Items

Type	Assigned to	User	Created	Due	Activity	Completed	Letter	Envelope
INN - Investigated - Disposed	MED - Issue Worker VAX		07/31/1996	01/28/1997	01/28/1997			
INN - Investigated - Disposed	MED - Issue Worker VAX		07/31/1996	01/26/1997	01/26/1997			
INN - Investigated - Disposed	MED - Issue Worker VAX		07/31/1996	01/28/1997	01/26/1997			
SEI - Review by Sec & Supv Mem	MED - Issue Worker VAX		07/31/1996	12/05/1996	01/26/1997			
INV - Investigation	MED - Issue Worker Beck, R		07/31/1996	08/20/1996	12/05/1996			
SEC - Initial Review by Sec & Supv Mem	MED - Issue Worker VAX		07/31/1996	07/31/1996	08/20/1996			
INI - Complaint Received	MED - Issue Worker VAX		07/31/1996	07/15/1996	07/31/1996			

Issue File Year:
Enter the issue file
year to search for

- [Close Window](#)
- [Print This Page](#)
- [Expand All](#) | [Collapse All](#)

1996-96153402

Number	1996-96153402	Status	Closed
Type	Complaint	Resolution Code	Other
Board	Medical Board	Resolution - Historical	MED-INN-Investigated-Disposed
Complaint Source	Other	Submitted Date	7/15/1996
If Other, Initiated By:	Data Conversion	Closed Date	1/28/1997
Route To		Owner	Data Administrator
Related Case		Owner Start Date	
Marked for Deletion		Days Owned	
ComplaintId/CredentialId		Name of Business at the Address	
License Type		License Renewal Number	
License Number			
Start Date			
Complainant Information			
Complainant Prefix		Complainant Email	
Complainant Full Name	Executive Staff	Complainant Phone (Main)	
Complainant First Name		Complainant Phone (Mobile)	
Complainant Middle Name		Complainant Phone (Alternate)	
Complainant Last Name		Complainant Mailing Address	
Complainant Suffix		Complainant City	
		Complainant State/ Prov.	Ohio
		Complainant Zip/ Post Code	

Respondent Information

Account Ohio State University Medical Center

Respondent Email

Contact

Respondent Phone (Main)

License Number (Respondent)

Respondent Phone (Mobile)

Related License Type

Respondent Phone (Alternate)

Respondent Prefix

Respondent Mailing Address

Respondent First Name Ohio State University Medical Center

Respondent City

Respondent Middle Name

Respondent State/ Prov.

Respondent Last Name

Respondent Zip/ Post Code

Respondent Suffix

Respondent Employer

Complaint Information

End Date

Willing to testify?

Description

Patient Name

Street

Patient Date of Birth

City

Reported to other Agency?

State/ Prov.

Agency Name

Zip/ Post Code

Other Agency Description

County

Country

Triager Information

Alleged Incident

Alleged Issues - Historical

FTR - Failure to report

ASAP

Priority - Historical

Undesignated

UNC Release Letter Sent

Category - Historical

MED - Data Conversion

UNC Response Requested

Licensure Triage Section

Request NPDB

Background Check Pending

Response Required

Triage Notes

90 Day Notice Required

90 Day Notice Sent

Request LEADS Report

Investigation Information

Priority Code

ROI Due Date

Date Complaint Sent to Investigator

Days Open

Enforcement Information

Priority Code

Enforcement Due Date

Initial Date Assigned to Enforcement

Standards Review Information

Standards Review Status

Standards Review Sub-Status

Subpoena Due Date

Review Due Date

System Information

Created By Data Administrator, 2/26/2016 3:19 AM

Record Type Medical_Board_Complaint

Last Modified By Data Administrator, 3/9/2016 10:12 PM

Historical ✓

Submissions

Create New Submission

Actions	Title	Description	Submission Time	Acknowledg e	Visibility	Uploads	Status	Complete
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Attachments

Actions	Attachment Name	Application Type	Application Number	Doc Uploaded to Onbase	Application Created Date	Board	Document Type
---------	-----------------	------------------	--------------------	------------------------	--------------------------	-------	---------------

Activity History

INN - Investigated - Disposed

Group	Type	Type	Status	Due Date	Completed Date	Assigned To	Comments
	Converted Action Item - No longer applicable		Completed		1/28/1997	Data Administrator	

SEI - Review by Sec & Supv Mem

Group	Type
-------	------

Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **1/28/1997**
 Assigned To **Data Administrator**
 Comments

INV - Investigation

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **12/5/1996**
 Assigned To **Data Administrator**
 Comments

SEC - Initial Review by Sec & Supv Mem

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **8/20/1996**
 Assigned To **Data Administrator**
 Comments

INI - Complaint Received

Group
 Type
 Type **Converted Action Item - No longer applicable**
 Status **Completed**
 Due Date
 Completed Date **7/31/1996**
 Assigned To **Data Administrator**
 Comments

INN - Investigated - Disposed

Group
 Type

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **1/28/1997**

Assigned To **Data Administrator**

Comments

INN - Investigated - Disposed

Group

Type

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **1/28/1997**

Assigned To **Data Administrator**

Comments

Complaint History

2/27/2016 11:25 AM

User **Data Administrator**

Action **Deleted Administrative Triage in Route To.**

2/26/2016 3:20 AM

User **Data Administrator**

Action **Changed Route To to Administrative Triage. Created.**

- ENFORCEMENT**
- Medical Board
- Issues**
- Search
- Add New
- Tickler
- Work Queue
- Work Queue Sort
- List Active
- Follow-Up List
- Enforcements**
- Search
- Add New
- Tickler
- Work Queue
- Work Queue Sort
- List Active
- Follow-Up List
- Legacy**

Issue View Screen

Case	1996-96099901	Date Received	05-16-1996	Addr	
Status	CLOSED	How Received	Data Conversion	Documents	
Respondent ID	[REDACTED]	Receiving Board	MEC	Entry Items	
Respondent	Updates Unavailable - Converted to eLicense 2.0	Receiving Department	MEC - Issue Worker	Notes	
Initiator ID	4007111	Received By	LEGACY DATA	Enforcement	
Initiator	STRAUSS, RICHARD H	Date Reviewed	05-16-1996		
		Category	MEC - Data Conversion		
		Priority	Undesignated		
		Docket/AG Number			
		Alleged Issues			
		FRO - Fraud			

Complaint:

Other Participants

No additional participants found

Resolution

Department	MED - Issue Worker	Found Issues	
Worker		Resolution Type	
Date Closed	11-07-1996	MED-INN- Investigated-Disposed	
		Last Worker:	

Resolution:

Action Items

Type	Assigned to	User	Created	Due	Activity	Completed	Letter	Envelope
INN - Investigated - Disposed	MED - issue Worker VAX		05-16-1996		11-07-1996	11-07-1996		
INV - Investigation	MED - issue Worker Baret: IA		05-16-1996		06-18-1996	11-07-1996		
INV - Investigation	MED - Issue Worker VAX		05-16-1996		06-17-1996	06-18-1996		
SEC - Initial Review by Sec & Supv Mem	MED - issue Worker VAX		05-16-1996		05-16-1996	06-17-1996		

Issue File Year:
Enter the issue file
year to search for

- [Close Window](#)
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1996-96099901

Number	1996-96099901	Status	Closed
Type	Complaint	Resolution Code	Other
Board	Medical Board	Resolution - Historical	MED-INN-Investigated-Disposed
Complaint Source	Other	Submitted Date	5/16/1996
If Other, Initiated By:	Data Conversion	Closed Date	11/7/1996
Route To		Owner	Data Administrator
Related Case		Owner Start Date	
Marked for Deletion		Days Owned	
ComplaintIdntCredentialIdnt		Name of Business at the Address	
License Type		License Renewal Number	
License Number			
Start Date			
Complainant Information			
Complainant Prefix		Complainant Email	
Complainant Full Name	STRAUSS, RICHARD H	Complainant Phone (Main)	6142933908
Complainant First Name		Complainant Phone (Mobile)	
Complainant Middle Name		Complainant Phone (Alternate)	
Complainant Last Name		Complainant Mailing Address	1501 DOONE ROAD
Complainant Suffix		Complainant City	COLUMBUS
		Complainant State/ Prov.	Ohio
		Complainant Zip/ Post Code	43221

Respondent Information

Account Respondent Email @osu.edu
 Contact Respondent Phone (Main) (614) 565-0959
 License Number (Respondent) Respondent Phone (Mobile)
 Related License Type Respondent Phone (Alternate)

Respondent Prefix Respondent Mailing Address
 Respondent First Name Respondent City
 Respondent Middle Name Respondent State/ Prov.
 Respondent Last Name Respondent Zip/ Post Code
 Respondent Suffix
 Respondent Employer

Complaint Information

End Date Willing to testify?
 Description Patient Name
 Street Patient Date of Birth
 City Reported to other Agency?
 State/ Prov. Agency Name
 Zip/ Post Code Other Agency Description
 County
 Country

Triager Information

Alleged Incident Alleged Issues - Historical FRO - Fraud
 ASAP Priority - Historical Undesignated
 UNC Release Letter Sent UNC Response Requested Category - Historical MED - Data Conversion

Licensure Triage Section

Request NPDB

Background Check Pending

Response Required

Triage Notes

90 Day Notice Required

90 Day Notice Sent

Request LEADS Report

Investigation Information

Priority Code

ROI Due Date

Date Complaint Sent to Investigator

Days Open

Enforcement Information

Priority Code

Enforcement Due Date

Initial Date Assigned to Enforcement

Standards Review Information

Standards Review Status

Standards Review Sub-Status

Subpoena Due Date

Review Due Date

System Information

Created By Data Administrator, 2/26/2016 2:58 AM

Record Type Medical_Board_Complaint

Last Modified By Data Administrator, 3/10/2016 12:14 AM

Historical



Submissions

Create New Submission

Actions	Title	Description	Time	Submission	Acknowledg	Visibility	Uploads	Status	Complete
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Attachments

Actions	Attachment Name	Application Type	Doc Uploaded to Onbase	Application Number	Created Date	Board	Document Type
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Activity History

INN - Investigated - Disposed

Group	Type	Converted Action Item - No longer applicable
	Status	Completed
	Due Date	11/7/1996
	Assigned To	Data Administrator
	Comments	

SEC - Initial Review by Sec & Supv Mem

Group	Type
-------	------

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **6/17/1996**

Assigned To **Data Administrator**

Comments

INV - Investigation

Group

Type

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **6/18/1996**

Assigned To **Data Administrator**

Comments

INV - Investigation

Group

Type

Type **Converted Action Item - No longer applicable**

Status **Completed**

Due Date

Completed Date **11/7/1996**

Assigned To **Marcia Barnett**

Comments

Complaint History

2/27/2016 11:25 AM

User **Data Administrator**

Action **Deleted Administrative Triage in Route To.**

2/26/2016 2:58 AM

User **Data Administrator**

Action **Changed Route To to Administrative Triage. Created.**

NAME John M. [unclear] M.D.
96-0999
COMPLAINT NUMBERS AND DATES

STATE MEDICAL I
ENFORCEMENT FILE

SECRETARY _____
SUPERVISING MEMBER _____

CLASSIFIED
EXEMPT FROM
DISSEMINATION

STATE MEDICAL BOARD
OF OHIO

MEMORANDUM

TO: Marcia L. Barnett, Investigator

FROM: John W. Rohal, Assistant Director/CJH



DATE: November 15, 1996

RE: _____, M.D.
Complaint # 96-0999

After reviewing your report of investigation it was decided to close this complaint.

Correspondence will be prepared and forwarded to the complainant.

CJH:jh

cc: William J. Schmidt, Assistant to the Director



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

February 12, 1997

Dr. [REDACTED], M.D.

[REDACTED] Ohio 43221

Dear Doctor Strauss:

This letter is to inform you of the outcome of the review of the complaint you filed regarding [REDACTED] M.D.

After thorough review, the Board's Secretary and Supervising Member decided that the situation outlined in your complaint does not support initiation of disciplinary action under Ohio's Medical Practices Act. Even though your complaint has been closed it will be kept on file.

Thank you for bringing your concerns to the Board's attention.

Sincerely yours,

A handwritten signature in cursive script that reads "Sue Bigham/pak".

Sue Bigham
Public Inquiries Officer

SB/pak



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

February 12, 1997

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, Ohio 43221

Dear Doctor Strauss:

This letter is to inform you of the outcome of the review of the
complaint you filed regarding M.D.

After thorough review, the Board's Secretary and Supervising Member
decided that the situation outlined in your complaint does not support
initiation of disciplinary action under Ohio's Medical Practices Act.
Even though your complaint has been closed it will be kept on file.

Thank you for bringing your concerns to the Board's attention.

Sincerely yours,

A handwritten signature in cursive script that reads "Sue Bigham/pak".

Sue Bigham
Public Inquiries Officer

SB/pak



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Board Member
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Robert S. Heidt, Sr., M.D.
Board Member
Cincinnati, Ohio

Bradley K. Sinnott, Esq.
Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

MEMORANDUM

TO: William J. Schmidt, Assistant to the Director *WJS*

FROM: Marcia L. Barnett, Investigator *MB*

DATE: October 9, 1996

RE: Report and Recommendation
 █ M.D.
 Complaint No. 96-0999A *close 7/29/96*

close 10/29/96

Enclosed is my report of investigation on the above matter. I did not find sufficient evidence to support the allegations made by the complainant, Dr. Strauss, in the above matter. However, there was evidence that Dr. [redacted] and [redacted], M.D. each failed to report allegations of sexual misconduct involving Dr. Strauss. The requirement to report such conduct is found in Medical Board rule 4731-15-01 (A). In addition, Dr. [redacted] failed to report a suspected case of a dangerous disease as required by Administrative Code rule 3701-3-02.

Based on my findings, I therefore recommend that Complaint No. 96-0999A be closed. The other findings, involving Dr. [redacted] and Dr. [redacted] are now being examined under Complaint No. 96-1534A & B.

E.C. 11-7-96 33. [redacted], M.D. - CLOSE

STATE MEDICAL BOARD
REPORT OF INVESTIGATION

COMPLAINT NO. <i>96-0999A</i>		DATE OF COMPLAINT <i>April 19, 1996</i>			TYPE OF COMPLAINT <i>FRO</i>		
COMPLAINANT:	LAST NAME	FIRST	MIDDLE	SEX	RACE	DOB OR AGE	
	<i>Strauss, M.D.</i>	<i>Richard</i>	<i>H.</i>	<i>M</i>		<i>7/30/38</i>	
ADDRESS: <i>1501 Doone Road Columbus, Oh 43221</i>					PHONE: <i>(614) 488-1094 (H)</i>		
COMPLAINT INVOLVES:	LAST NAME	FIRST	MIDDLE	SEX	RACE	DOB OR AGE	
	<i>, M.D.</i>			<i>M</i>			
ADDRESS: <i>Columbus, Oh 43220</i>					PHONE: <i>(614) (w)</i>		
<p>INVESTIGATIVE ACTION</p> <p><i>See attached Report</i></p>							
INVESTIGATOR <i>Marcia L. Barnett</i>				DATE <i>10/9/96</i>	HOURS <i>45</i>		
WITNESS:	LAST NAME	FIRST	MIDDLE	SEX	RACE	AGE	
ADDRESS:					PHONE:		
WITNESS:	LAST NAME	FIRST	MIDDLE	SEX	RACE	AGE	
ADDRESS:					PHONE:		

Supplemental Sheet
Re: _____, M.D.
Date: April 19, 1996

Page / of 17
Complaint No.: 96-0999A

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Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

SYNOPSIS

On April 19, 1996 the Medical Board received a letter of complaint from Richard H. Strauss, M.D. The complaint alleged that _____, M.D., _____ at The Ohio State University, ordered Dr. Strauss to falsify the medical records of a student seen by Dr. Strauss at the Student Health Services on January 5, 1996. Dr. Strauss further alleged that Dr. _____ ordered a staff member, Judy Brady, Assistant Director of Student Health Services, to destroy a viable chlamydia culture, that Dr. Strauss obtained from the patient.

On June 20, 1996 Investigator Barnett conducted an interview of Dr. Strauss to discuss the details of his allegations. In the lengthy discussion that followed, Dr. Strauss explained that he had conducted a detailed physical examination of this student and had obtained a gonococcal and chlamydia culture. He made a preliminary diagnosis of nongonococcal gonorrhea and a urological problem that he identified as premature ejaculation. Dr. Strauss explained that the student became highly agitated at the end of the office visit when they were discussing his findings. According to Dr. Strauss, the student grabbed the medical charts and ripped up the contents. He also threw both cultures to the floor, causing the GC culture to open up. However, the chlamydia culture remained intact.

Dr. Strauss told Investigator Barnett that the student made allegations of sexual misconduct against Dr. Strauss and used his family connections to influence Dr. _____ to order Dr. Strauss to conceal documentation related to the nature of the urological problem. According to Dr. Strauss, Dr. _____ wanted him to document that this student had refused any treatment from Dr. Strauss. Dr. Strauss told Investigator Barnett that he had wanted to submit his "usual" descriptive notes concerning this student's examination but was told he could not by Dr. _____. Dr. Strauss produced a copy of those notes during the interview with Investigator Barnett. However, this investigation found that Dr. Strauss actually prepared a different progress note for Dr. _____ on January 5, 1996 and produced a second progress note at his administrative hearing before University officials in June of 1996. The first progress note did not reveal that any incident occurred, while the second progress note was more specific about the student's agitated behavior and the urological problem. Dr. Strauss said that he was suspended from Student Health Services following the January incident.

Dr. Strauss denied the student's allegations of sexual misconduct. However, Dr. Strauss revealed that two previous complaints of sexual misconduct had been made against him, although he claimed that each had been resolved. Dr. Strauss' appointment to Student Health Services was not renewed based on the findings of the University's administrative hearing.

Supplemental Sheet

Page 3 of 17

Re: M.D.

Complaint No.: 96-0999A

Date: April 19, 1996

Interviews with Dr. Dr. , Judy Brady, and confirmed that there were previous incidents of alleged sexual misconduct involving Dr. Strauss. However, none of these allegations were previously reported to the Medical Board. Investigator Barnett submitted a new complaint regarding the allegations of sexual misconduct.

Statements from Dr. Dr. , and Judy Brady do not support the claims made by Dr. Strauss that he was "ordered" to report that the student refused treatment. According to Dr. and Ms. Brady, the decision as to what to report was mutually agreed upon

and that Dr. Strauss did not object to writing that statement at that time. Dr. *stated that Dr. Strauss made remarks to him following this incident that indicated that he was in agreement to report that the student had refused treatment.

Dr reported to Investigator Barnett that he alone decided to destroy the two cultures, including the viable chlamydia culture. He determined that the student had refused treatment by his actions. Dr. did acknowledge that he wrote the student a prescription for Doxycycline without conducting any physical examination or taking any cultures. He explained that he prescribed this course of treatment based solely on the student's report of being exposed to chlamydia and was now experiencing symptoms.

The medical records, dated January 5, 1996, do not reflect that the student reported to Dr. that he was exposed to chlamydia. Chlamydia is a Class A reportable disease, according to the Ohio Administrative Code rule 3701-3-02. Individual case reports are required within 24 hours. Dr. may be in violation of this rule.

This investigation revealed that Dr. had knowledge of several incidents involving Dr. Strauss and allegations of sexual misconduct, yet he failed to report those allegations to the Medical Board. As a result, Dr. may have violated Rule 4731-15-01 (A) of the State Medical Board of Ohio. This same violation may apply to Dr. as well since he became aware of the allegations concerning Dr. Strauss following the January 5, 1996 incident. Possible violations of this Rule are being investigated under Complaint No. 96-1534B.

This investigation revealed that Dr. Strauss may have violated Sections 4731.22 (B)(10),(12),(14) and (19). However, evidence of these possible violations is being investigated under Complaint No. 96-1534A.

In conclusion, this investigation did not find any evidence to support the specific allegations reported by Dr. Strauss. However, other violations, as stated above, may have occurred and are the subject of other investigations.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Supplemental Sheet
Re: M.D.
Date: April 19, 1996

Page 4 of 17
Complaint No.: -96-0999A-... ..

IDENTITY OF LICENSEE

NAME:

SSN:

Redacted

DOB:

OCCUPATION: Medical Doctor

SPECIALTY:

BUSINESS ADDRESS: The Ohio State University
Student Health Services
1875 Millikin Road
Columbus, OH 43210

HOME ADDRESS:

MEDICAL LICENSE:

EXPIRATION DATE: 9/30/98

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

10/07/96

MDMAST

09:31:54

(Last)

(First)

(Title)

1) Name:

Addr1:

Addr2:

City: COLUMBUS

Cnty: 25 FRANKLIN

Addr1: STUDENT HEALTH SERVICES

Addr2: 1875 MILLIKIN RD

City: COLUMBUS

Cnty: 25 FRANKLIN

ST:OH

Zip: 43220

ST:OH

Zip: 43210

Filenum: [REDACTED]

3) SRS Status: 3A ACTIVE LIC

Issue Date: 06/20/96

Expire Date: 09/30/98

Fee: \$ 000.00

Audit Num: 027158

BK PG LN

Fiscal: 00 000 00

00 000 00

2) Sex: M Birth:

Deceased:

SSN: [REDACTED]

City: DENNISON

Pull Status:

ST:OH Country:

Decision Date: 00/00/00

How Issued: F OHIO FLEX

Date: 08/13/76 4)

Specialty:

Treas. Ret. Date: 05/14/96

MEEP: 00/00/00

Batch No: 027409

Cert. Mailed Date: 00/00/00

Last Update: 06/05/96

Graduation:

By: SRS

School: 03840

-----There is NO Formal-Action-Summary for this record.-----PRESS<Return>

WITNESSES

1. Richard H. Strauss, M.D.
1501 Doone Road
Columbus, Ohio 43221
(614) 488-1094
(or)
The Ohio State University
B101 Starling-Loving Hall
Columbus, Ohio 43210
(614) 293-3908

Dr. Strauss can testify to the existence and accuracy of medical records of Patient A, identified in the Confidential Patient Key, and to specific discussions he had with Dr. [REDACTED] about the medical records of Patient A.

2. Judith L. Brady
Assistant Director for Administration
The Ohio State University
Student Health Services
1875 Millikin Road
Columbus, OH 43210-2200
(614) 292-0110

Ms. Brady can testify as to the existence and accuracy of discussions with Patient A and his mother regarding Patient A's request regarding medical record documentation and to the existence and accuracy of discussions with Dr. [REDACTED] and Dr. Strauss regarding the documentation of the physical examination in Patient A's medical records.

Dr. [REDACTED] can testify as to the existence and condition of bio-cultures of Patient A and to the details of his contact with Patient A following that patient's physical examination by Dr. Strauss.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

10/07/96

MDMAST

09:30:19

1) Name: STRAUSS (Last) RICHARD HARRY (First) (Title) File Num: 35-042299
 Addr1: B 101 STARLING-LOVING HALL
 Addr2: OHIO STATE UNIVERSITY HOSPITAL
 City: COLUMBUS ST:OH
 Cnty: 25 FRANKLIN Zip: 432100000
 Addr1:
 Addr2:
 City:
 Cnty: 00 ST:
 Zip: 000000000

3) SRS Status: 3A ACTIVE LIC
 Issue Date: 06/20/96
 Expire Date: 09/30/98
 Fee: \$ 000.00
 Audit Num: 027278
 BK PG LN
 Fiscal: 00 000 00
 00 000 00

2) Sex: M Birth: 07/30/38 Deceased: 00/00/00
 SSN: Redacted City: CHICAGO
 ST:IL Country:
 How Issued: N END NATL BDS Date: 07/11/78 4)
 Specialty:

Pull Status:
 Decision Date: 00/00/00

Cert. Mailed Date: 00/00/00 MEEP: 00/00/00
 Graduation: 06/12/64
 School: 01602 UN OF CHICAGO, PRITZKER SM, CHICAGO

Treas. Ret. Date: 05/13/96
 Batch No: 025309
 Last Update: 05/13/96
 By: SRS

-----There is NO Formal Action Summary for this record.-----PRESS<Return>

10/07/96

SEARCH

09:36:35

1 961534A STRAUSS, RICHARD H
Ty: SEXUAL IMPROPRIETIES

By: BRADY, JUDY
Stat: INVESTIGATION

Inv: KRB

2 961534B OSU HOSPITALS
Ty: FAILURE TO REPORT

By: CSMB/RAY BUMGARNER -
Stat: INVESTIGATION

Inv: KRB

DATE: 10/07/96

STATE OF OHIO MEDICAL BOARD
COMPLAINT TRACKING

TIME: 09:40:04

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+-----+
| 1. NAME: OSU HOSPITALS                               LICENSE:    LICENSE NO: 000000 |
| COMPLAINT TYPE: FTR-FAILURE TO REPORT                TYPE DATE: 07/31/96 |
|      : -                                             |
|      : -                                             |
| COMPLAINT STATUS: INV-INVESTIGATION                  STATUS DATE: 08/20/96 |
| SUPERVISE BD MEM: RJA-RAYMOND ALBERT                 |
| BOARD SECRETARY: TEG-THOMAS E. GREYER, MD           |
| INVESTIGATOR: KRB-KEVIN R. BECK                     |
| ENFORCEMENT CO: -                                    PRIORITY CODE: |
| COMPLAINT NUMBER: 961534B   NOTE:                   |
+-----+

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+-----+
| 2. SOURCE TYPE: -                                     |
| COMPLAINANT NAME: OSMB/RAY BUMGARNER - EXEC DIR     LIC.RPT: N |
| ADDRESS:                                             |
| ADDRESS:                                             |
| CITY: COLUMBUS                                       STATE: OH  ZIP: 43266-0000 |
| PHONE: (000)000-0000                                ADDRESS UPDATED: 07/31/96 |
+-----+

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Supplemental Sheet
Re: _____, M.D.
Date: April 19, 1996

Page 6 of 17
Complaint No.: 96-0999A

EVIDENCE

- D-1. Medical chart of Patient A, obtained by subpoena, from The Ohio State University, Student Health Service, J. W. Wilce Student Health Center, 1875 Millikin Road, Columbus, Ohio 43210.
- D-2. Copy of Dr. Strauss' complaint, dated April 19, 1996
- D-3. Correspondence submitted by Dr. Strauss on June 20, 1996
- D-4. Correspondence submitted by Dr. Strauss on June 26, 1996
- D-5. List of Reportable Diseases obtained from Judy Brady on July 15, 1996

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

See Evidence Envelope D-1



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Board Member
Cincinnati, Ohio

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Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

MEMORANDUM

TO: Marcia L. Barnett, Investigator

FROM: William J. Schmidt, Assistant to the Director *WJS*

DATE: June 18, 1996

RE: M.D.
Complaint No. 96-0999A

The attached complaint(s) is assigned to you for investigation.

WJS:jag

STATE MEDICAL BOARD OF OHIO
COMPLAINT TRACKING FORM

Complaint Number 96-0999A

COMPLAINT INVOLVES:

			Secretary	Supervising Member
Name (last)	(first)	(MD, DO, DPM, etc.)		
Address _____			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
City <u>Columbus</u> State <u>Oh</u> Zip <u>43220</u>				
Ohio License Number _____				
Complaint Type <u>PRO</u>				
No priors <input checked="" type="checkbox"/>				
Complaint numbers _____				
On site list? <input checked="" type="checkbox"/>				
Yes _____ Enf. Coordinator _____				
			Investigation	
			Refer to	
			Office Conf.	
			Reason?	
			To Accomplish?	
			Vol. Surrender	
			Staff Review	
			Citation/Deny	
			Prosecutor	
			No further action	
			Other	
			Date/Initials	<u>5/30/96</u> <u>[Signature]</u>

Cross References: _____

COMMENTS:

PRO Ltr.

EC 6/17/96 55.

, MD - INVESTIGATION

96 APR 19 PM 4:49

STATE MEDICAL BOARD

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
Home telephone: (614) 488-1094
Office telephone: (614) 293-3908

April 19, 1996

Dr. Thomas E. Gretter, Secretary
Ohio State Medical Board
77 South High Street
Seventeenth Floor
Columbus, OH 43266-0315

Re: Complaint of Ethical Misconduct Against _____, M.D.

Dear Dr. Gretter:

I, Richard H. Strauss, M.D., with deep regret and great sadness, find it necessary to petition the Ohio State Medical Board to review the unethical and unprofessional behavior of _____, M.D., _____ at The Ohio State University. On January 5, 1996, Dr. _____ engaged in fraudulent and deceptive practices by directing me to falsify a patient's medical record and by directing another of his subordinates to destroy a viable culture taken from the same patient.

These acts are contrary to the American Medical Association Principles of Medical Ethics and in direct violation of the laws governing the profession of the State of Ohio. Ohio Revised Code §4731, which governs the Practice of Medicine in Ohio, prohibits any acts which violate A.M.A. Ethics Principles as well as acts that are illegal under the criminal statutes. [Ohio Rev. Code Ann. §4731.22(B)(10), (12), (18).] Specifically, the law of the State of Ohio stipulates that it is illegal to "falsify, destroy, remove, conceal, alter, deface or mutilate any writing, data, or record." [§2913.42 (A).] This crime is a felony. In addition, A.M.A. Principle II calls for a physician to deal honestly with patients and colleagues, free of fraud and deception. I believe that the conduct set forth below is unethical and illegal.

In addition to the original acts of fraud, _____ has violated Principles II and IV of the A.M.A. Principles of Medical Ethics and consequently Ohio Revised Code §4731.22(B)(18) through his conduct toward me. _____ has jeopardized my professional reputation by attempting to coerce my complicity in these acts and by perpetuating unfounded accusations made by the patient with regard to my professional examination.

The facts surrounding this incident are as follows:

Dr. Thomas E. Gretter
April 19, 1996
Page 2

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STATE MEDICAL BOARD

At present, I am a tenured Professor of Public Health in the College of Medicine at The Ohio State University. In addition to my responsibilities in the School of Public Health, I am a practicing physician at The Ohio State University's Student Health Services. I have worked part-time at the Student Health Services for sixteen years, much of that time as Director of the Sports Medicine Clinic. I also have been a Team Physician for the O.S.U. Athletic Department for the past seventeen years.

During the past three years, I have been the Director of the Student Health Services' Men's Clinic, which I founded. In that clinic, I treat a large number of students--about 1,500 patient-visits in 1995.

He treats about one-tenth that number of Men's Clinic patients. He is a full-time employee at the Student Health Services.

The Men's Clinic is patterned after a gynecology clinic except that it is for men. More than half of what I diagnose and treat consists of sexually transmitted diseases. Other common problems include scrotal masses; testicular pain; dermatological problems of the pubic, genital and perineal areas; prostatitis; and sexual dysfunctions such as premature ejaculation and impotence. These are, naturally, sensitive subjects for most of my patients, and most of the patients are rather nervous when they first walk into my office. This is often their first experience with a genitourinary medical problem or examination. I have a limited time to make them comfortable enough to talk about and deal with their problem or, frequently, their multiple genitourinary problems.

On January 5, 1996, a 19 year-old Ohio State University student, henceforth referred to as "the patient", sought treatment at the Men's Clinic for symptoms consistent with a sexually transmitted disease. In fact, he was found by me to have one sexually transmitted disease and an additional urological problem.

After the conclusion of the history, physical examination, two urethral cultures, and discussion of the treatment plan for the sexually transmitted disease, we discussed the urological problem. The patient seemed uncomfortable discussing the history of the urological problem.

Then I said, "I guess we're finished". I reached for the computer on my desk and said to the patient, "I'll let you read your medical write-up". The patient looked startled and became agitated for the first time during his visit. He uttered an epithet at me and abruptly left the examination room. As the

Dr. Thomas E. Gretter
April 19, 1996
Page 3

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STATE MEDICAL BOARD

patient passed the receptionist and left the waiting room, he shouted something which neither the receptionist nor I could understand.

A few minutes later, Dr. [redacted] entered my office and said that my "last patient" wanted to see his record. I told [redacted] that I would meet him and the patient immediately in [redacted]'s office, down the hall.

[redacted] left and I picked up the patient's records and his two urethral cultures from my office and walked across the waiting room toward the hallway to [redacted]'s office. I saw the patient at that time, confronting and verbally abusing [redacted], and demanding that she purge the records of his visit from the computer system in front of her. She denied his request.

At that moment, the patient saw me and shouted "I want my records. I want the paper I signed". I said, "Come on and we'll talk," as I walked toward [redacted] office. The patient ran after me and wrenched the medical records from my hands, scattering the cultures on the hallway floor. He then rapidly walked back into the [redacted] room, approached [redacted], and again demanded that she remove all information about him from the computer system. He tore up medical records and threw various items at [redacted]. The patient then left the Men's Clinic.

Minutes later, [redacted] initial reaction was, "We should call the campus police".

Within the next few minutes I talked about this incident with [redacted] with Ms. Judy Brady, the Assistant Director of the Student Health Services; and then in private with [redacted]

[redacted] said that the patient had talked to him and had accused me of inappropriate touching, which I denied. I offered my explanation for the patient's behavior: specifically, that the patient would go to any extreme to prevent me from recording my urological findings in his medical record.

[redacted] said that the patient was from "a well-connected and influential family from [redacted]". [redacted] said that the patient's mother had called and that she was quite "reasonable". She only insisted that "Dr. Strauss not be allowed to write anything in [the patient's] record" and that "get rid of Dr. Strauss".

Dr. Thomas E. Gretter
April 19, 1996
Page 4

96 APR 19 PM 4:49

STATE MEDICAL BOARD

My write-up of every initial patient-visit is printed in detail in the patient's record because I produce it on my computer in the presence of the patient. _____ instructed me that I was not to write my usual report about this patient. I objected. I said that I could not even imagine what to write if it wasn't my usual, printed report. _____ said that he would ask Judy Brady to come in and they would determine what I should write in the patient's record.

Ms. Judy Brady joined us in _____ office. She was carrying a plastic culture tube. She said that the culture in the petri dish (gonorrhoea) was destroyed because it lay open on the hallway floor, but the culture (chlamydia DNA probe) in her hands was still good (viable) because the plastic tube was still undamaged and the top was still on tight. What should she do with it, Ms. Brady asked. _____ ordered her to destroy the viable chlamydia culture.

Ms. Brady sat down. The three of us then discussed the patient's interactions with all of those involved: 1) me; 2) 3) Ms. Brady; 4) _____; and 5)

_____ and Ms. Brady then discussed what I should write in the patient's record--specifically, the words that would satisfy the patient's mother.

I objected, since I thought I was supposed to write a complete record in the patient's chart. _____ replied that if I wanted to write up my report, he would "put it in a secret place--where it would not be found if there were an investigation". I declined.

_____ then said that I could write whatever I wanted and keep it at home. At that point I hand-wrote and signed a sentence in the patient's record, as dictated by _____ : that the patient had ... "refused treatment".

Before I left the Men's Clinic the same day, I wrote an accurate record of the patient's visit and took the record home.

Shortly after assaulting _____, the patient visited _____ told me that he gave the patient an antibiotic for a sexually transmitted disease based on the patient's history. _____ said he did not do a physical examination nor take any cultures.

It is the sum of these acts--creating a false record, destroying a viable culture, and suppressing the accurate record--

Dr. Thomas E. Gretter
April 19, 1996
Page 5

-that demonstrates the intent to commit fraud in violation of the law and the ethical code of the profession.

As a result of the patient's unfounded accusations against me and ; unethical actions prejudicial against me,

suspended my clinical privileges at the Men's Clinic and as Team Physician for the Athletic Department, and placed me on paid administrative leave.

conduct has been unprofessional, unethical, and in violation of Ohio law. Therefore, it should be examined immediately by the Board.

I would appreciate the Board's attention to this matter. I will make myself available to the Secretary and others who are responsible for the investigation.

Sincerely,



Richard H. Strauss, M.D.
Ohio Medical License 35-04-2299

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96 APR 19 PM 4:49



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Board Member
Columbus, Ohio

Anita M. Steinbergh, D.O.
Board Member
Westerville, Ohio

May 17, 1996

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, Ohio 43221

Dear Dr. Strauss:

Thank you for referring your concerns about
to the State Medical Board. This information has been
forwarded to the Secretary and Supervising Member of the
Board for further consideration.

We appreciate the opportunity to review this matter.

Sincerely yours,

Sue Bigham
Public Inquiries Officer

SB/pak

See Evidence Envelope D-3

See Evidence Envelope D-4

REPORTABLE DISEASES

Ohio Administrative Code rule 3701-3-02 details the list of diseases that are classified as "Class A", Class B", and "Class C". These diseases are declared to be dangerous to the public health and are made notifiable. The occurrence of cases or suspected cases shall be reported as provided in this rule and rules 3701-3-03 to 3701-3-31 of the Administrative Code.

CLASS A (Individual case reports required within 24 hours)

- (1) Diseases of major public health concern because of endemicity and/or potential for epidemic spread.

Campylobacter	Legionnaires' Disease
Chlamydial infections	Measles
(nonspecific urethritis,	Meningococcal disease
cervicitis, salpingitis,	Meningitis, aseptic, including
neonatal conjunctivitis,	lymphocytic choriomeningitis,
pneumonia, and lympho-	and viral meningoencephalitis
granuloma venereum)	Meningitis, other bacterial
<u>E. coli</u> 0157:H7	Mumps
Encephalitis	Mycobacterial disease
Arthropod-borne	Tuberculosis
Other viral	Other
Post-infection	Pelvic Inflammatory Disease,
Giardiasis	Gonococcal
Gonococcal infections	Pertussis
Haemophilus influenzae	Reye Syndrome
invasive disease	Rocky Mountain Spotted Fever
Hemolytic uremic syndrome	Rubella (including congenital
(HUS)	rubella syndrome)
Hepatitis A	Salmonellosis
Hepatitis B	Shigellosis
Hepatitis C	Syphilis
Hepatitis non-A, non-B	

- (2) Low frequency diseases of major public health concern

Amebiasis	Lyme Disease
Anthrax	Malaria
Botulism	Mucocutaneous Lymph Node
Brucellosis	Syndrome (Kawasaki Disease)
Chancroid	Plague
Cholera	Poliomyelitis (including
Cytomegalovirus (congenital	vaccine-associated)
only)	Psittacosis (Ornithosis)
Dengue	Rabies
Diphtheria	Rheumatic Fever
Granuloma inguinale	Smallpox
Herpes (congenital only)	Streptococcal B in newborn
Leprosy	Sudden Infant Death Syndrome
Leptospirosis	(SIDS)
Listeriosis	Tetanus

REPORTABLE DISEASES, con. d

(2) Low frequency diseases of major public health concern, cont.

Toxic Shock Syndrome	Typhus Fever
Toxoplasmosis (congenital)	Vibrosis
Trichinosis	Yellow Fever
Tularemia	Yersinosis
Typhoid Fever	

CLASS B (Report by number of cases only)

Chicken Pox	Influenza
Herpes-genital	Streptococcal infections

CLASS C (Report situation when epidemic is suspected)

Blastomycosis	Pediculosis
Conjunctivitis, acute	Scabies
Diarrhea of newborn	Sporotrichosis
Foodborne disease	Staphylococcal skin infections
Histoplasmosis	Toxoplasmosis
Infectious mononucleosis	Waterborne disease
Nosocomial infections of any type	

THE ABOVE DISEASES ARE TO BE REPORTED TO THE LOCAL HEALTH DEPARTMENT WHERE THE PATIENT LIVES--FOR EASY REFERENCE, LIST THE LOCAL HEALTH DEPARTMENTS IN YOUR AREA BELOW.

AIDS, ARC, and positive HIV tests are reportable per section 3701-3-12 of the Ohio Administrative Code.

All cases of Acquired Immunodeficiency Syndrome (AIDS), AIDS-related complex (ARC), and all confirmed positive tests for infection with the human immunodeficiency virus (HIV) must be reported to the local health department (LHD) designated to receive such reports for each individual county.

Reporting will be to the designated health department where the physician's or dentist's office, hospital, or laboratory is physically located. Information regarding AIDS, ARC, and HIV reporting in your county may be obtained by calling any health department in the county.

NOTE: Criteria for confirmed positive HIV tests are defined in Section 3701-3-10 of the Ohio Administrative Code. Copies of this section can be obtained by writing to:

REPORTABLE DISEASES, cont'd

Surveillance Section
AIDS Activities Unit
Ohio Department of Health
P. O. Box 118
Columbus, Ohio 43266-0118
(614) 644-1844

Supplemental Sheet

Page 7 of 17

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

INTERVIEW OF: Richard H. Strauss, M.D.

ADDRESS: 1501 Doone Road
Columbus, OH 43221

PHONE: (614) 488-1094

DATE/PLACE: June 20, 1996
State Medical Board of Ohio
77 S. High Street 17th Floor
Columbus, OH 43266-0315

Investigator Barnett interviewed Dr. Strauss regarding allegations that he was directed by his supervisor, _____, to alter the medical records of a nineteen year old (19) male patient that Dr. Strauss saw at the Student Health Services' Men's Clinic, at The Ohio State University, on January 5, 1996.

Dr. Strauss said that this patient made accusations that he had inappropriately touched him and used inappropriate language during a physical examination. Dr. Strauss denied these allegations. He said that the patient became highly agitated and partially destroyed his medical chart and cultures following a physical examination and discussion with Dr. Strauss.

Dr. Strauss said that _____ ordered him to write "refused treatment" in lieu of his detailed findings and diagnosis of this patient. Dr. Strauss said that he complied with _____ orders, but did so under duress. Dr. Strauss maintained a copy of his initial diagnoses and findings, and gave me a copy of it during this interview.

Dr. Strauss said that his clinical practice privileges were suspended on January 8, 1996 as a result of the allegations made by this patient.

Dr. Strauss explained that he had not seen this patient prior to January 5, 1996 and that the patient had not been seen by any other physicians at the Men's Clinic previously, to his knowledge.

The patient's chief complaint was "urinary tract infection" as written by the patient on the intake form. However, upon examination, Dr. Strauss determined that this patient had nongonococcal urethritis, possibly from chlamydia. He performed two cultures: one for chlamydia and one for gonorrhea. He also determined that the patient had a problem with premature ejaculation, because the patient began to get an erection during the examination and then suddenly ejaculated.

Dr. Strauss detailed his examination of this patient and his findings in a letter to _____
_____ June 5, 1996.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

Dr. Strauss fully detailed the patient's behavior during and after the examination in this letter as well. A copy of the letter was obtained.

Dr. Strauss said that Judy Brady, Assistant Director, Student Health Services, witnessed the discussion on January 5, 1996 in which ordered Dr. Strauss to write "refused treatment". He said that Ms. Brady was ordered by to destroy the remaining viable chlamydia culture.

Dr. Strauss said that there is no official [due process] for Student Health Services related incidents as it is not part of the University Hospital system. Dr. Strauss said that he had an opportunity to explain his version of the incident to and
t., of Human Relations, on June 5, 1996 in the presence of his attorney, Tim Nagy. However, Dr. Strauss did not believe there was any formal investigation by the University to evaluate the evidence. Dr. Strauss said that will make the final decision on his suspension sometime this summer, although no specific date has been set for that determination.

I asked Dr. Strauss if he could think of any other reason or the University Administration might have for suspending his clinical privileges. He said that it might be age discrimination. Dr. Strauss said that he has not pursued any civil action against the University. He provided me copies of other correspondence related to this incident.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Supplemental Sheet
Re:
Date: April 19, 1996

Page 9 of 17
Complaint No.: 96-0999A

INTERVIEW OF: Judith L. Brady
Assistant Director for Administration
ADDRESS: The Ohio State University
Student Health Services
1875 Milliken Road
Columbus, OH 43210-2200
PHONE: (614) 292-0110
DATE/PLACE: July 15, 1996
The Ohio State University
Student Health Services

Investigator Barnett interviewed Ms. Brady in the presence of

2-

Ms. Brady said that Richard Strauss, M.D., held a 20% appointment with Student Health Services at The Ohio State University. He is a full-time tenured faculty member in the School of Health. Dr. Strauss saw patients about 2 hours per day, 4 to 5 days per week, at Student Health Services.

Ms. Brady said that Dr. Strauss was placed on administrative leave from his appointment at Student Health Services on or about January 6, 1996 following an incident involving his examination of an 18 year old male patient in the "Men's Clinic". Both Ms. Brady and said that there had been several other incidences of a sexual nature involving Dr. Strauss and his examination of male patients at Student Health Services.

Ms. Brady and said that they were informed by Dr. Strauss' attorney, Tim Nagy, that Dr. Strauss filed a complaint with the Medical Board against , sometime after Dr. Strauss' suspension.

said that Dr. Strauss also served as a team physician for several OSU athletic teams as part of a contractual arrangement with the Athletic Department. This was under the direction of and . However, Dr. Strauss was asked not to perform any team physician functions following the January 1996 incident, according to

Ms. Brady said that on or about January 5, 1996 she learned that a male student became extremely agitated during a physical examination with Dr. Strauss and caused a commotion in the waiting area of Student Health Services. While highly agitated, the student tore up pages from his medical chart and destroyed two culture specimens obtained from him during the examination.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

Ms. Brady said that she did not witness this incident but became involved in the situation at the request of _____, another Student Health Services physician. Ms. Brady said that _____ came to her office shortly after the incident took place and asked her to talk to the student.

The student asked Ms. Brady to remove all information from his medical records that would show that he was examined by Dr. Strauss. Ms. Brady said that she did not promise the student that she would be able to do that. Ms. Brady said that she also spoke by telephone to the student's mother that same day. The mother reiterated the student's wishes that he did not want any information in the medical records about his visit to Dr. Strauss. The student also told Ms. Brady that he still wanted to be seen by someone and treated for what was believed to be a sexually transmitted disease (STD). Ms. Brady said that she arranged for the student to be seen by _____.

Ms. Brady said that the student told her that Dr. Strauss touched him inappropriately during the examination and that Dr. Strauss used obscene language to describe anatomy and bodily functions. Dr. Strauss allegedly also asked inappropriate questions about the student's sexual relations. Ms. Brady said that the student told her that he knew what a proper examination is as he had been examined for STD's in the past by other doctors and knew what to expect. The student also told Ms. Brady that Dr. Strauss told him that he became erect and ejaculated during the examination. The student told Ms. Brady that he did not know if that happened, according to Ms. Brady.

Ms. Brady said that on or about January 5, 1996, after meeting with the student, she met with _____ and Dr. Strauss to discuss what to do with the student's medical records. Ms. Brady described the meeting atmosphere as collegial. She said that it was mutually decided to document that the student had refused treatment rather than to use documentation provided by Dr. Strauss at that meeting which did not reflect the student's agitated behavior or that the student [allegedly] had an erection and ejaculated during the examination. Ms. Brady said that Dr. Strauss did not object to writing that the student refused treatment.

Ms. Brady said that it was her understanding from _____ that both cultures taken from the student were not viable because the lids had come off of both when the student threw them on the floor. Ms. Brady said that she did not witness the student throw the cultures on the floor. She said that _____ did not order _____ or her to destroy the cultures.

Ms. Brady said that the normal process is to have the students hand carry their specimens to the laboratory for processing. She said that she was not aware of any preliminary diagnosis of any STD and did not recall if Dr. Strauss noted that in his physician's note. Ms. Brady said that their Student Health Services laboratory is responsible for reporting certain diseases to the Ohio Department of Health. The physician does not have that responsibility.

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

Ms. Brady did not know if nongonococcal gonorrhea is a reportable disease. She obtained a copy of the reportable disease list (Ohio Administrative Code rule 3701-3-02) and we reviewed it during this interview. It did not appear that nongonococcal gonorrhea was reportable.

Ms. Brady said that she had not seen the student's medical chart and did not know what information was in the chart. She did not know what specific information was destroyed by the student.

said that Dr. Strauss was not entitled to a due process hearing on this matter since he held a 20% appointment, which technically is not a clinical appointment. However, they did hold a hearing in June of 1996 with Dr. Strauss and his attorney. The hearing was conducted by . At the hearing, Dr. Strauss produced a medical chart note that he claimed he planned to put in the student's medical chart until told not to by . said that the medical note said that the student became erect and ejaculated during the examination, which is information that was not included in the notes produced by Dr. Strauss in January, according to Ms. Brady.

said that will soon render a decision regarding Dr. Strauss's appointment.

added that Dr. Strauss' attorney sent a letter to the student in February of 1996, with a copy to another University official, who was not involved in this matter. The letter identified that the student by name and indicated that he had an STD. felt that the letter was threatening "put up or shut up" and disclosed patient confidential information to a "nonparty".

Supplemental Sheet
Re:
Date: April 19, 1996

Page 12 of 17
Complaint No.: 96-0999A

INTERVIEW OF:

-and-

ADDRESS: Student Health Services
The Ohio State University
1875 Milliken Road
Columbus, OH 43210-2200

DATE/PLACE: August 6, 1996
The Ohio State University
Student Health Services

Investigator Barnett interviewed _____ and _____ in the presence of _____

_____ said that he has been the Director of Student Health Services for the past 4 years. He is also a clinical assistant professor in family practice medicine and preventive medicine. _____ said that he is currently _____ es where he has been for _____

_____ said that Dr. Strauss is currently on administrative leave with pay from Student Health Services as a result of an incident with a patient, seen in the Men's Clinic at Student Health Services, that occurred in January of 1996. _____ aid that the patient, an 18 year old male student, was extremely upset after being examined by Dr. Strauss. The student told _____ that Dr. Strauss had touched him inappropriately and used inappropriate language during the examination. _____ said that there were several other complaints by students about Dr. Strauss' physical examinations, previously.

_____ said that a letter is being sent to Dr. Strauss advising him that his appointment with Student Health Services will not be renewed. She did not know what impact this might have on Dr. Strauss' other employment with the University or with any other University appointment.

_____ id that they had not met or talked with the student prior to this incident in January of 1996. They did not believe the student had ever been a patient of _____

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re: _____ D.

Complaint No.: 96-0999A

Date: April 19, 1996

Student Health Services previously as his patient chart was blank at the time of his appointment with Dr. Strauss in January. _____ I not know if Dr. Strauss had had any prior contact with this student.

_____ said that he first became involved in this matter in January when he observed the student at the receptionist's desk. The student was agitated and was demanding his medical records from _____. He also demanded that she erase his records from the computer. The student had just been examined by Dr. Strauss, according to _____. _____ attempted to talk to the student but the student just wanted his medical chart.

_____ said that he tried to have the student meet with him and Dr. Strauss but the student refused, and grabbed his medical chart from Dr. Strauss when he saw him in the hallway. _____ witnessed the student rip up the medical chart. _____ said that he retrieved the GC auger plate and chlamydia tube from the floor where they had been thrown by the student.

_____ said that the GC auger plate was open and face down. The chlamydia tube was intact. _____ said that he decided to destroy the two cultures, as, in his opinion and based on the student's actions, the student had refused treatment. _____ said that he was not advised or instructed by anyone to destroy the two cultures; he did so of his own accord. He said that Judy Brady, Assistant Director for Administration, Student Health Services, was with him at the time he retrieved the two cultures and that he discussed his plan to destroy the cultures with her.

_____ added that students are financially responsible for any labwork and prescriptions through Student Health Services. Therefore, when a student refuses treatment, they do not process any labwork.

I asked _____ if he knew why the student wanted all his medical records removed.

_____ speculated that the student did not want Dr. Strauss to have any access to information whereby he could trace the student. The student even wanted any record of his appointment erased.

_____ said that he retained the torn pieces of the medical chart in an envelope which he maintains separately from the student's new medical chart. _____ said that they could not locate, among the torn pieces, the student's signature on a questionnaire that students fill out when they enter the clinic. The questionnaire asks students if they want another person present during their examination, among other things.

_____ said that he did see the student later that day, at the student's request. The student had told Judy Brady that he wanted to be seen by another doctor for treatment,

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

but not on the same floor as he was seen earlier. Ms. Brady arranged for [redacted] to see the student in a room on the first floor of the Student Health Services. According to [redacted], the student asked for a prescription antibiotic and refused to be examined and refused to have any cultures taken. The student told [redacted] that he had been exposed to chlamydia by his partner and just wanted to be treated for that.

[redacted] said that he wrote a prescription for Doxycycline. According to [redacted], its an oral antibiotic, to be taken for seven (7) days. [redacted] said that he documented in the student's medical chart that he saw the patient, that the patient was asymptomatic per the patient, and that he prescribed an antibiotic. No follow-up appointment was scheduled. [redacted] said that he has not seen the student since.

[redacted] added that it is an acceptable practice of care to prescribe antibiotics for suspected STD's without any examination or cultures. He said that there is no policy or requirement to follow up on this treatment. The STD is not reportable to the Department of Health, according to [redacted]

[redacted] said that he spoke with the student's mother the day of the incident. He described the mother as understanding, cooperative, and open. According to [redacted] the mother did not ask him to remove any information from the student's medical records and did not ask him to take any specific action against Dr. Strauss. The mother arranged for her son to meet with [redacted] the next day.

[redacted] said that he spoke with the student, in private, in his office. The student described the examination and remarks made by Dr. Strauss. The student was in tears, according to [redacted] [redacted] said that the student told him that he was familiar with the procedures in examinations for STDs and that this examination was very unlike any he had had before. It was [redacted] opinion that the student was upset about "the total package" and not any one specific thing that occurred during the examination, as Dr. Strauss alleged.

[redacted] said that he had a meeting the day of the incident or perhaps the next day, with Ms. Brady and Dr. Strauss to discuss what information to put in the student's medical chart. According to [redacted] Dr. Strauss showed him and Ms. Brady a one-page printout from his personal computer that described the physical examination, his preliminary diagnosis of urethritis, the labwork, and awaiting lab results. However, there was no mention of the student's agitated behavior or of the alleged erection and ejaculation. [redacted] said that he objected to this write-up since he failed to mention the student's behavior. He recommended that Dr. Strauss add a line or two about the incident.

[redacted] said that Dr. Strauss refused to include any mention about the incident.

[redacted] said that he offered to keep the copy of the medical note presented by Dr. Strauss in a confidential file, not to be part of the student's actual medical file. Dr. Strauss refused

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

Re:

Complaint No.: 96-0999A

Date: April 19, 1996

to give him the note and asked what he wanted him to put in the student's chart. suggested then that the medical chart reflect that the student refused treatment. added that it was Dr. Strauss that asked for his opinion on the matter as to what to put in the chart, since he did not want to detail the student's actual behavior. He said that Dr. Strauss left his office after this discussion and wrote another note for the medical chart.

added that after Dr. Strauss prepared a handwritten note for the medical chart, which said that the patient refused treatment, he showed it to He told him that "this is what we agreed to".

said that the student's medical records will show note that he prescribed an antibiotic and the 2 line note by Dr. Strauss that the patient refused treatment and was seen by another physician.

said that showed him a copy of a typed medical note that Dr. Strauss produced at his hearing with , in June of 1996. said that the information in this note about his examination of the student was substantially different than the note Dr. Strauss showed him in January of 1996. According to his note identified that the student became erect and ejaculated during the examination and that the student became visibly upset. The note further stated that the student refused treatment from Dr. Strauss but was seen by

and said that they did not reveal to Dr. Strauss that the student had been seen by until some time after the incident.

I asked and if Dr. Strauss' actions with regard to this student violated any university policies or procedures. They could not think of any violations. I asked and if there had ever been any other incident involving Dr. Strauss where a patient's medical file information was changed or if Dr. Strauss had been instructed to prepare some information for the chart that was different than he proposed. They could not think of any such instance.

I asked if a formal complaint had been made by the student or his family regarding this situation. said that "we considered it a formal complaint when the parent called back" and with the student talking with Ms. Brady who handles Student Health Services quality assurance. added that quality assurance materials are maintained separately and are not kept in the physician's personnel file.

Supplemental Sheet
Re:
Date: April 19, 1996

Page 16 of 17
Complaint No.: 96-0999A

SUBPOENAS

1. Investigative Subpoena Duces Tecum, dated August 30, 1996, was issued for the medical records of Patient A. The subpoena was served on _____, on August 30, 1996. The compliance date was September 24, 1996.

The complete medical record, including insurance claim forms, was obtained on September 27, 1996. The record was reviewed and copied on the University premises at the request of the _____

Investigator: Marcia L. Barnett

Date Submitted: October 9, 1996

STATE OF OHIO
THE STATE MEDICAL BOARD
77 South High Street
17th Floor
Columbus, Ohio 43266-0315

INVESTIGATIVE
SUBPOENA DUCES TECUM

DATE August 30, 1996

We hereby command you to summon _____ or Records Custodian, Wilce
Student Health Center, The Ohio State University, 1875 Milliken Rd., Columbus, OH 43210
or other responsible individual having custody and control of records, to appear in the
offices of the State Medical Board of Ohio, in the city of Columbus, County of Franklin,
State of Ohio, on the 24th day of September A.D. 1996, at 11:00 o'clock A. M.,
then and there to produce and deliver documents to the State Medical Board of Ohio, to
wit: To produce the complete, original patient records for the patients identified on the
attached Patient Key. For purposes of this Subpoena Duces Tecum, medical records shall
include, but not necessarily be limited to, radiology and laboratory reports and results;
descriptions and results of all tests of any type; descriptions, visual or audio-visual
recordings, and narrations of all diagnostic and surgical procedures; hospital records;
records related to itemization of charges; treatment or practice plans; and all records
pertaining to history, conditions, treatment, diagnosis, prognosis, etiology or expense and
billing, including all records obtained from other physicians, from hospitals and from
other health care providers.

This you shall in nowise omit under penalty of the law, and have then and there
this writ.

(SEAL)

STATE MEDICAL BOARD OF OHIO


Secretary

sub-key
2/20/96

Ref. Number 960999A-I-01

Fees	
Mileage	\$ _____

Total	\$ _____

RETURN OF SERVICE
(PERSONAL)

I received this summons on August 29,
1996, at 12:50 o'clock, p.m., and made
personal service of it upon _____

(Fill in name)
by locating /him/her/ and tendering a copy of
the summons and accompanying documents on:

August 30, 1996

Marcus L. Barrett, Investigator
Serving Officer, Title

Date return made: August 30, 1996.

RETURN OF SERVICE
(FAILURE OF SERVICE)

I received this summons on _____
19____ at _____ o'clock, ____m., with
instructions to make /personal service/residence
service/ upon _____ and
(Fill in name)
I was unable to serve a copy of the summons
upon /him/her/ for the following reasons:

Serving Officer, Title

Date return made: _____, 19____.

RETURN OF SERVICE
(RESIDENCE)

I received this summons on _____

19____, at _____ o'clock, ____m., and made

residence service of it upon _____
(Fill in name)

by leaving at /his/her/ usual place of residence
with _____ a person of
(Fill in name)

suitable age and discretion then residing
therein, a copy of the summons and
accompanying documents, on _____,

19____.

Serving Officer, Title

Date return made: _____, 19____.

PATIENT KEY

KEY CONFIDENTIAL PURSUANT TO O.R.C. 4731.22(C)(1)
TO BE WITHHELD FROM PUBLIC DISCLOSURE

This subpoena shall include any and all medical records for the below identified patient(s) for medical services rendered at The Ohio State University, Wilce Student Health Center, including, but not limited to, the Men's Clinic.

1.

ssn# [Redacted]

RECORDS AND DOCUMENTS REVIEWS

D-1. Medical Records of Patient A

The records revealed that the student was seen at The Ohio State University, Student Health Service, on January 5, 1996 by Dr. Strauss. Dr. Strauss recorded that the student refused treatment from him but was then seen by

's notes reflect that the patient was referred to him on January 5, 1996 and that the student refused to be examined and refused to have any cultures. tid
prescribe "Doxy 100 bid x 7d" for an unspecified urinary tract infection.

The medical records did not report that the student was examined by Dr. Strauss or that any laboratory cultures were taken by Strauss on January 5, 1996. The medical records also do not reflect that there was any incident involving Dr. Strauss and this patient.

D-2. Self Explanatory

D-3. Correspondence submitted by Dr. Strauss

Within the correspondence is a medical progress note for Patient A, dated January 5, 1996. The progress note was marked [Exhibit] 4, apparently since it was produced at the University's administrative hearing in June of 1996. This progress note detailed Dr. Strauss' examination of Patient A and is purported to have been created at the time of the examination on January 5, 1996. However, witnesses revealed that this note was probably created some time after that since it contained information not available to Dr. Strauss on January 5, 1996 and that it was substantially different in content to a progress note Dr. Strauss showed on January 5, 1996.

Dr. Strauss told Investigator Barnett that this was the progress note he wanted to put in Patient A's medical records on January 5, 1996 but that rejected it.

D-4. Self Explanatory

D-5. Self Explanatory

STATE OF OHIO
THE STATE MEDICAL BOARD
77 South High Street
17th Floor
Columbus, Ohio 43266-0315

INVESTIGATIVE
SUBPOENA DUCES TECUM

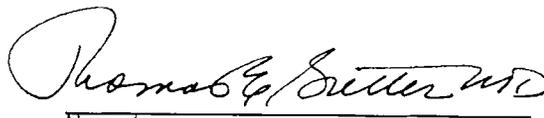
DATE August 30, 1996

We hereby command you to summon _____ or Records Custodian, Wilce
Student Health Center, The Ohio State University, 1875 Milliken Rd., Columbus, OH 43210
or other responsible individual having custody and control of records, to appear in the
offices of the State Medical Board of Ohio, in the city of Columbus, County of Franklin,
State of Ohio, on the 24th day of September A.D. 1996, at 11:00 o'clock A. M.,
then and there to produce and deliver documents to the State Medical Board of Ohio, to
wit: To produce the complete, original patient records for the patients identified on the
attached Patient Key. For purposes of this Subpoena Duces Tecum, medical records shall
include, but not necessarily be limited to, radiology and laboratory reports and results;
descriptions and results of all tests of any type; descriptions, visual or audio-visual
recordings, and narrations of all diagnostic and surgical procedures; hospital records;
records related to itemization of charges; treatment or practice plans; and all records
pertaining to history, conditions, treatment, diagnosis, prognosis, etiology or expense and
billing, including all records obtained from other physicians, from hospitals and from
other health care providers.

This you shall in nowise omit under penalty of the law, and have then and there
this writ.

(SEAL)

STATE MEDICAL BOARD OF OHIO


Secretary

sub-key
2/20/96

Ref. Number 960999A-I-01

Fees	
Mileage	\$ _____

Total	\$ _____

RETURN OF SERVICE
(PERSONAL)

I received this summons on August 29,
19 96, at 12:50 o'clock, p.m., and made
personal service of it upon
(Fill in name)
by locating /him/her/ and tendering a copy of
the summons and accompanying documents on:

August 30, 19 96.
Marcia F. Barnett, Investigator
Serving Officer, Title

Date return made: August 30, 19 96.

RETURN OF SERVICE
(FAILURE OF SERVICE)

I received this summons on _____
19 ____ at _____ o'clock, ____ .m., with
instructions to make /personal service/residence
service/ upon _____ and
(Fill in name)
I was unable to serve a copy of the summons
upon /him/her/ for the following reasons:

Serving Officer, Title
Date return made: _____, 19 ____.

RETURN OF SERVICE
(RESIDENCE)

I received this summons on _____
19 ____, at _____ o'clock, ____ .m., and made
residence service of it upon _____
(Fill in name)
by leaving at /his/her/ usual place of residence
with _____ a person of
(Fill in name)
suitable age and discretion then residing
therein, a copy of the summons and
accompanying documents, on _____,
19 ____.

Serving Officer, Title
Date return made: _____, 19 ____.

PATIENT KEY

KEY CONFIDENTIAL PURSUANT TO O.R.C. 4731.22(C)(1)
TO BE WITHHELD FROM PUBLIC DISCLOSURE

This subpoena shall include any and all medical records for the below identified patient(s) for medical services rendered at The Ohio State University, Wilce Student Health Center, including, but not limited to, the Men's Clinic.

1.

ssn# **Redacted**

203

STATE OF OHIO
THE STATE MEDICAL BOARD

AUTHORIZATION FOR ISSUANCE OF INVESTIGATIVE
SUBPOENA FOR PATIENT RECORDS

Authorization is hereby granted to issue a subpoena to _____ or Records Custodian, Wilce Student Health Ctr., The Ohio State University, 1875 Milliken Rd., Columbus, OH 43210, requiring the production of the following information: The complete, original patient records for the patients identified on the attached Patient Key. Medical records shall include, but not necessarily be limited to, radiology and laboratory reports and results; descriptions and results of all tests of any type; descriptions, visual or audio-visual recordings, and narrations of all diagnostic and surgical procedures; hospital records; records related to itemization of charges; treatment or practice plans; and all records pertaining to history, conditions, treatment, diagnosis, prognosis, etiology or expense and billing, including all records obtained from other physicians, from hospitals and from other health care providers.

This authorization is made pursuant to investigation of complaint number(s) 96-0999A a copy of which is attached hereto. The authorized subpoena is to be used for the purpose of investigation of a possible violation of Chapter 4730. or 4731., Ohio Revised Code, or a rule of the State Medical Board, to wit:

Section 4731.22 (B)(6) & (B)(18), Ohio Revised Code

Before authorizing issuance of the above described subpoena the undersigned have determined that there is probable cause to believe that the attached complaint alleges a violation of Chapter 4730. or Chapter 4731., Ohio Revised Code, or rule of the State Medical Board; that the records sought are relevant to the alleged violation and material to the investigation; and that the records cover a reasonable period of time surrounding the alleged violation.

[Signature] 7/25/96
Secretary (Date)
[Signature] 7/11/96
Supervising Member (Date)
[Signature] 7/25/96
Board Member (Date)

I, [Signature], Assistant Attorney General, state that the staff of the State Medical Board have consulted with me regarding this matter. My comments are as follows:

etc to issue

[Signature] 7/25/96
Assistant Attorney General (Date)

orgpatrc
rev. 2/20/96

Ref. Number 960999A-1-01



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MEMORANDUM

TO: William J. Schmidt, Assistant to the Director

FROM: Marcia L. Barnett, Investigator *MB*

DATE: July 1, 1996

RE: Request for Authorization of Subpoena
Complaint No. 96-0999A

In order to examine the allegations made in the above complaint it will be necessary to obtain and review the medical records of the patient identified on the attached Confidential Patient Key. The medical records are purported to reflect that the patient refused treatment, including examination by the attending physician, when, in fact, the patient was examined and a preliminary diagnosis was rendered.



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MEMORANDUM

TO: Marcia L. Barnett, Investigator

FROM: William J. Schmidt, Assistant to the Director 

DATE: June 18, 1996

RE: Complaint No. 96-0999A

The attached complaint(s) is assigned to you for investigation.

WJS:jag

STATE MEDICAL BOARD OF OHIO
COMPLAINT TRACKING FORM

Complaint Number 96-0999A

COMPLAINT INVOLVES:

Secretary

Supervising
Member

Name _____
(last) (first) (MD, DO, DPM, etc.)

Address _____

City Columbus State Oh Zip _____

Ohio License Number _____

Complaint Type 1120

No priors

Complaint numbers _____

On site list?
No

Yes _____ Enf. Coordinator _____

Investigation

Refer to _____

Office Conf. _____

Reason? _____

To Accomplish? _____

Vol. Surrender _____

Staff Review _____

Citation/Deny _____

Prosecutor _____

No further action _____

Other _____

Date/Initials 5/30/96 [Signature] 11/96

Cross References: _____

COMMENTS:

PRO Ltr

EC 6/17/96 55. [REDACTED]

INVESTIGATION

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
Home telephone: (614) 488-1094
Office telephone: (614) 293-3908

95 APR 19 PM 11:49

STATE MEDICAL BOARD OF OHIO

April 19, 1996

Dr. Thomas E. Gretter, Secretary
Ohio State Medical Board
77 South High Street
Seventeenth Floor
Columbus, OH 43266-0315

Re: Complaint of Ethical Misconduct Against

Dear Dr. Gretter:

I, Richard H. Strauss, M.D., with deep regret and great sadness, find it necessary to petition the Ohio State Medical Board to review the unethical and unprofessional behavior of

On January 5, 1996, I engaged in fraudulent and deceptive practices by directing me to falsify a patient's medical record and by directing another of his subordinates to destroy a viable culture taken from the same patient.

These acts are contrary to the American Medical Association Principles of Medical Ethics and in direct violation of the laws governing the profession of the State of Ohio. Ohio Revised Code §4731, which governs the Practice of Medicine in Ohio, prohibits any acts which violate A.M.A. Ethics Principles as well as acts that are illegal under the criminal statutes. [Ohio Rev. Code Ann. §4731.22(B)(10), (12), (18).] Specifically, the law of the State of Ohio stipulates that it is illegal to "falsify, destroy, remove, conceal, alter, deface or mutilate any writing, data, or record." [§2913.42 (A).] This crime is a felony. In addition, A.M.A. Principle II calls for a physician to deal honestly with patients and colleagues, free of fraud and deception. I believe that the conduct set forth below is unethical and illegal.

In addition to the original acts of fraud, has violated Principles II and IV of the A.M.A. Principles of Medical Ethics and consequently Ohio Revised Code §4731.22(B)(18) through his conduct toward me. has jeopardized my professional reputation by attempting to coerce my complicity in these acts and by perpetuating unfounded accusations made by the patient with regard to my professional examination.

The facts surrounding this incident are as follows:

Dr. Thomas E. Gretter
April 19, 1996
Page 2

96 APR 19 PM 10:49
STATE MEDICAL BOARD OF OHIO

At present, I am a tenured Professor of Public Health in the College of Medicine at The Ohio State University. In addition to my responsibilities in the School of Public Health, I am a practicing physician at The Ohio State University's Student Health Services. I have worked part-time at the Student Health Services for sixteen years, much of that time as Director of the Sports Medicine Clinic. I also have been a Team Physician for the O.S.U. Athletic Department for the past seventeen years.

During the past three years, I have been the Director of the Student Health Services' Men's Clinic, which I founded. In that clinic, I treat a large number of students--about 1,500 patient-visits in 1995.

treats about one-tenth that number of Men's Clinic patients. He is a full-time employee at the Student Health Services.

The Men's Clinic is patterned after a gynecology clinic except that it is for men. More than half of what I diagnose and treat consists of sexually transmitted diseases. Other common problems include scrotal masses; testicular pain; dermatological problems of the pubic, genital and perineal areas; prostatitis; and sexual dysfunctions such as premature ejaculation and impotence. These are, naturally, sensitive subjects for most of my patients, and most of the patients are rather nervous when they first walk into my office. This is often their first experience with a genitourinary medical problem or examination. I have a limited time to make them comfortable enough to talk about and deal with their problem or, frequently, their multiple genitourinary problems.

On January 5, 1996, a 19 year-old Ohio State University student, henceforth referred to as "the patient", sought treatment at the Men's Clinic for symptoms consistent with a sexually transmitted disease. In fact, he was found by me to have one sexually transmitted disease and an additional urological problem.

After the conclusion of the history, physical examination, two urethral cultures, and discussion of the treatment plan for the sexually transmitted disease, we discussed the urological problem. The patient seemed uncomfortable discussing the history of the urological problem.

Then I said, "I guess we're finished". I reached for the computer on my desk and said to the patient, "I'll let you read your medical write-up". The patient looked startled and became agitated for the first time during his visit. He uttered an epithet at me and abruptly left the examination room. As the

Dr. Thomas E. Gretter
April 19, 1996
Page 3

96 APR 19 PM 4:49

patient passed the receptionist and left the waiting room, he shouted something which neither the receptionist nor I could understand.

A few minutes later, entered my office and said that my "last patient" wanted to see his record. I told that I would meet him and the patient immediately in down the hall.

left and I picked up the patient's records and his two urethral cultures from my office and walked across the waiting room toward the hallway to . I saw the patient at that time. Confronting and verbally abusing , and demanding that she purge the records of his visit from the computer system in front of her. She denied his request.

At that moment, the patient saw me and shouted "I want my records. I want the paper I signed". I said, "Come on and we'll talk," as I walked toward . The patient ran after me and wrenched the medical records from my hands, scattering the cultures on the hallway floor. He then rapidly walked back into the reception room, approached , and again demanded that she remove all information about him from the computer system. He tore up medical records and threw various items at [REDACTED]. The patient then left the Men's Clinic.

Minutes later, initial reaction was, "We should call the campus police".

Within the next few minutes I talked about this incident with ; with Ms. Judy Brady, the Assistant Director of the Student Health Services; and then in private with

said that the patient had talked to him and had accused me of inappropriate touching, which I denied. I offered my explanation for the patient's behavior: specifically, that the patient would go to any extreme to prevent me from recording my urological findings in his medical record.

said that the patient was from "a well-connected and influential family from ". said that the patient's mother had called and that she was quite "reasonable". She only insisted that "Dr. Strauss not be allowed to write anything in [the patient's] record" and that "get rid of Dr. Strauss".

Dr. Thomas E. Gretter
April 19, 1996
Page 4

STATE MEDICAL BOARD
96 APR 19 PM 6:49

My write-up of every initial patient-visit is printed in detail in the patient's record because I produce it on my computer in the presence of the patient. [redacted] instructed me that I was not to write my usual report about this patient. I objected. I said that I could not even imagine what to write if it wasn't my usual, printed report. [redacted] said that he would ask Judy Brady to come in and they would determine what I should write in the patient's record.

Ms. Judy Brady joined us in [redacted] She was carrying a plastic culture tube. She said that the culture in the petri dish (gonorrhea) was destroyed because it lay open on the hallway floor, but the culture (chlamydia DNA probe) in her hands was still good (viable) because the plastic tube was still undamaged and the top was still on tight. What should she do with it, Ms. Brady asked. [redacted] ordered her to destroy the viable chlamydia culture.

Ms. Brady sat down. The three of us then discussed the patient's interactions with all of those involved: 1) me; 2) [redacted]; 3) Ms. Brady; 4) [redacted]; and 5)

[redacted] and Ms. Brady then discussed what I should write in the patient's record--specifically, the words that would satisfy the patient's mother.

I objected, since I thought I was supposed to write a complete record in the patient's chart. [redacted] replied that if I wanted to write up my report, he would "put it in a secret place--where it would not be found if there were an investigation". I declined.

[redacted] then said that I could write whatever I wanted and keep it at home. At that point I hand-wrote and signed a sentence in the patient's record, as dictated by Dr. [redacted]: that the patient had ..."refused treatment".

Before I left the Men's Clinic the same day, I wrote an accurate record of the patient's visit and took the record home.

Shortly after assaulting [redacted] the patient visited [redacted] [redacted] told me that he gave the patient an antibiotic for a sexually transmitted disease based on the patient's history. [redacted] said he did not do a physical examination nor take any cultures.

It is the sum of these acts--creating a false record, destroying a viable culture, and suppressing the accurate record--

Dr. Thomas E. Gretter
April 19, 1996
Page 5

-that demonstrates the intent to commit fraud in violation of the law and the ethical code of the profession.

As a result of the patient's unfounded accusations against me and [redacted]'s unethical actions prejudicial against me, [redacted] at The Ohio State University (not a physician), suspended my clinical privileges at the Men's Clinic and as Team Physician for the Athletic Department, and placed me on paid administrative leave.

[redacted]; conduct has been unprofessional, unethical, and in violation of Ohio law. Therefore, it should be examined immediately by the Board.

I would appreciate the Board's attention to this matter. I will make myself available to the Secretary and others who are responsible for the investigation.

Sincerely,



Richard H. Strauss, M.D.
Ohio Medical License 35-04-2299

STATE MEDICAL BOARD
96 APR 19 PM 4:59



STATE MEDICAL BOARD OF OHIO

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May 17, 1996

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, Ohio 43221

Dear Dr. Strauss:

Thank you for referring your concerns about M.D. to the State Medical Board. This information has been forwarded to the Secretary and Supervising Member of the Board for further consideration.

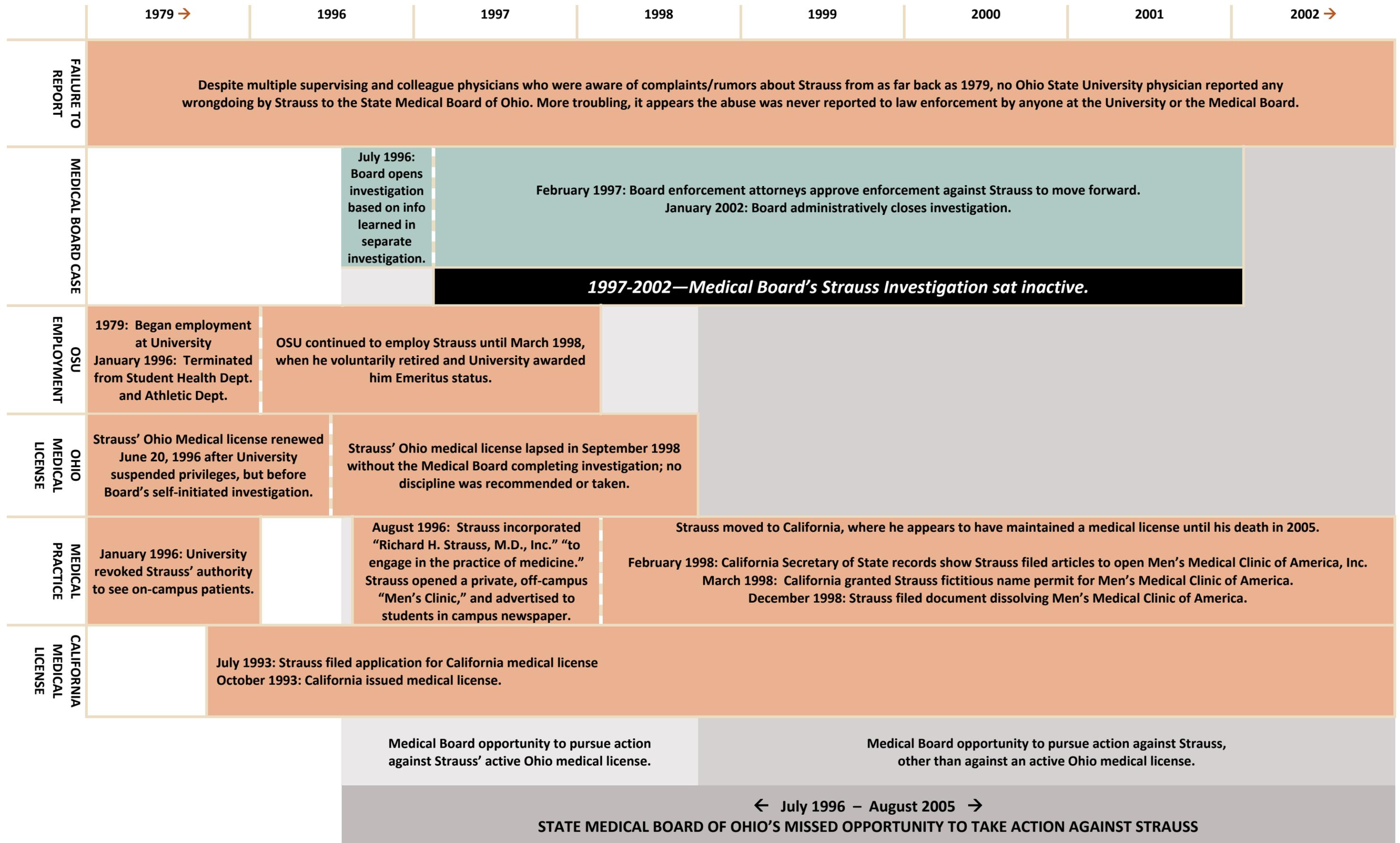
We appreciate the opportunity to review this matter.

Sincerely yours,

Sue Bigham
Public Inquiries Officer

SB/pak

Timeline of Events: Richard Strauss



Investigation	Date (Complainant)	Subject	Secretary /Supervising Member Initial Review	Inv. opened	Inv. Closed/ Report Date	Investigator conclusion/ recommendation	Secretary /Supervising Member Post-Investigation Review	Case closed (by whom)	Case closing mechanism (from whom)
1996-1534 A	7/15/96 (Board initiated through Marcia Barnett Memo; note July 31, 1996 letter to Judith L. Brady in Student Health Services thanking her for referral of concerns)	Strauss	Per tracking program entries on legacy cases: <ul style="list-style-type: none"> 7/31/96: submitted for review 8/20/96: review completed 	8/22/96	12/4/96	Investigation “shows that Dr. Strauss has been performing inappropriate genital exams on male students for years. This has been brought to the attention of officials at the university and just recently action was taken. This report is submitted for your review and consideration.” The report then stated: “As long as names of athletes continue to be brought to my attention the investigation will continue.”	Per tracking program entries on legacy cases: <ul style="list-style-type: none"> 12/5/96: submitted for review 1/3/97: review completed 1/3/97: assigned to enforcement 	1/25/02 (not identified) Tracking program entries on legacy cases show enforcement review closed and case marked “Disposed”	No letter; handwritten notes on case cover sheet indicate closure
1996-1534 B	7/15/96 (Board initiated – Marcia Barnett memo)	OSU	Per tracking program entries on legacy cases: <ul style="list-style-type: none"> 7/31/96: submitted for review 8/20/96: review completed 	8/22/96	12/4/96: Beck report indicates both case numbers or 1/6/97: memo from Chief Enforcement Coordinator Diann Thompson recommends closure because opened in error inasmuch as Student Health Services was not associated in any way with the OSU hospitals	12/4/96: Beck report makes no specific finding re OSU hospitals or 1/6/97: memo from Chief Enforcement Coordinator Diann Thompson finds opened in error	Per tracking program entries on legacy cases: <ul style="list-style-type: none"> 12/5/96: submitted for review 1/28/97: review completed 1/28/97: marked “Disposed” 	1/30/97 (John Rohal memo, indicating decision to close “this portion of this complaint”)	Rohal memo; no letter to complainant as no complainant identified



STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X *Richard Harry Strauss*
(SIGNATURE OF APPLICANT)

4/30/96
SHS
(DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-2299	\$250.00	05/01/96
RICHARD HARRY STRAUSS, M.D. B 101 STARLING-LOVING HALL OHIO STATE UNIVERSITY HOSPITAL COLUMBUS OH 43210		

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

IM INTERNAL MEDICINE

SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET _____
STREET _____
CITY _____ STATE _____ ZIP CODE _____
COUNTY _____

⑆969696962⑆

0935042299⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street _____
Street _____
City _____ State _____ Zip Code _____
County _____

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

YES NO

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO

YES NO

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO

YES NO

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

YES NO

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO

YES NO

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

YES NO

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

YES NO

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO

YES NO

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221.
Office telephone: (614) 293-3908
Home telephone: (614) 488-1094
April 30, 1996

Urgent

Dr. Thomas E. Gretter, Secretary
Ohio State Medical Board
77 South High Street
Columbus, OH 43266-0315

Dear Dr. Gretter:

Please help me. I would like to resume my practice of medicine. I have, in fact, been suspended from any practice of medicine for the past four months by David Williams, the Vice-president for Student Affairs at The Ohio State University. In thirty years of medical practice, the last eighteen years in Ohio, I have never been subjected to such unfair treatment.

Mr. Williams suspended my clinical privileges at the O.S.U. Student Health Services on January 8, 1996, and they are still suspended. The details surrounding this never-ending saga are contained in my letter to you dated April 19, 1996, a copy of which is attached.

Mr. Williams, who is a lawyer and not a physician, has been the sole arbiter of this matter. He refuses to hold any unbiased hearing or follow any due process involving a panel of physicians to hear the medical facts concerning this matter--even though there are many physicians available at the O.S.U. Medical Center and even a committee to look into medical complaints.

Mr. Williams is the top medical administrator for the Student Health Services. He apparently feels he has the power to hire and fire physicians and to suspend their clinical privileges "at his pleasure". He believes he is answerable to no one else in these matters. The O.S.U. Medical Center (where I am a tenured Professor of Public Health) falls under a different O.S.U. vice-president, who has no jurisdiction over the Student Health Services. Mr. Williams' actions as a medical administrator are unjust and a danger to every physician who works at the Student Health Services. Are there no rules that apply to medical administrators, no limits to their power to suspend--without "due process"--a physician licensed by the Ohio State Medical Board?

I am on the "strict full-time" medical faculty of the University. My contract prohibits me from practicing medicine outside the

STATE MEDICAL BOARD
97 APR 30 AM 11:57

University (except for national service, etc). Thus, Mr. Williams' actions have, in effect, suspended my medical license for the past four months--without due process and without recourse. When will this end?

Not your problem, perhaps you are thinking. Unfortunately, it is. Specifically, my Ohio medical license is up for renewal, and I understand that Medical Boards look with suspicion on doctors who have had their clinical privileges suspended. So I am asking you to look into this matter carefully, because you are the only body with the jurisdiction to do so.

I request that you to look into my clinical suspension as soon as you can fit it onto your schedule so I can practice medicine again. Another reason for swift action is that I have been chosen as one of the physicians for the Summer Olympics in Atlanta. There are 750 physicians who have been selected to provide the medical care for the Olympics. All of them are from Georgia except for 20 physicians chosen from across the United States. I am one of those 20 physicians. Please note the attached letter from the Chief Medical Officer for the Olympics to the Medical Board of Georgia requesting my licensure in Georgia.

A clear problem for me is that I cannot apply for the Georgia license while I am on clinical suspension--unless you look into this matter and make a written determination. If you find me guilty of any wrongdoing, then I'm sure you will also find an appropriate punishment, and working at the Olympics would then be the least of my worries. On the other hand, if you find me innocent, I can get on with my life, the Olympics, and the practice of medicine.

For the past ten years I have been the Editor-in-chief of *The Physician and Sportsmedicine*, one of the largest medical journals in the U.S. Unfortunately, because of the stigma associated with this prolonged clinical suspension, my position with that journal is in jeopardy. I ask that you look into this matter as soon as possible to take it out of the realm of, "you are guilty because Mr. Williams says you are guilty."

Thank you for taking the time to read this letter.

Sincerely,

Richard H. Strauss
Richard H. Strauss, M.D.
Ohio Medical License 35-04-2299

97 APR 30 8:11:57

STATE MEDICAL BOARD
OF OHIO



7111 N 1111

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

Date: June 11, 1996

RICHARD H STRAUSS MD
OHIO ST UNIVERSITY
B101 STARLING-LOVING HALL
COLUMBUS OH 43210

Dear Doctor:

In reviewing your renewal application we noted your affirmative answer to the question "At any time since signing your last application for renewal of your certificate have you had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?"

We are requesting that you forward a brief explanation of your answer, including the name and location of the hospital involved and the date of the action.

Thank you for your prompt attention to this matter.

Sincerely,

John W. Rohal
Assistant Director

JWR:jdc

Fin,

Richard H. Strauss, M.D.
1501 Doone Road
Columbus, OH 43221
Office telephone: (614) 293-3908
Home telephone: (614) 488-1094
June 18, 1996

Mr. John Rohal
State Medical Board of Ohio
77 South High Street, 17th Floor
Columbus, OH 43266-0315

Dear Mr. Rohal:

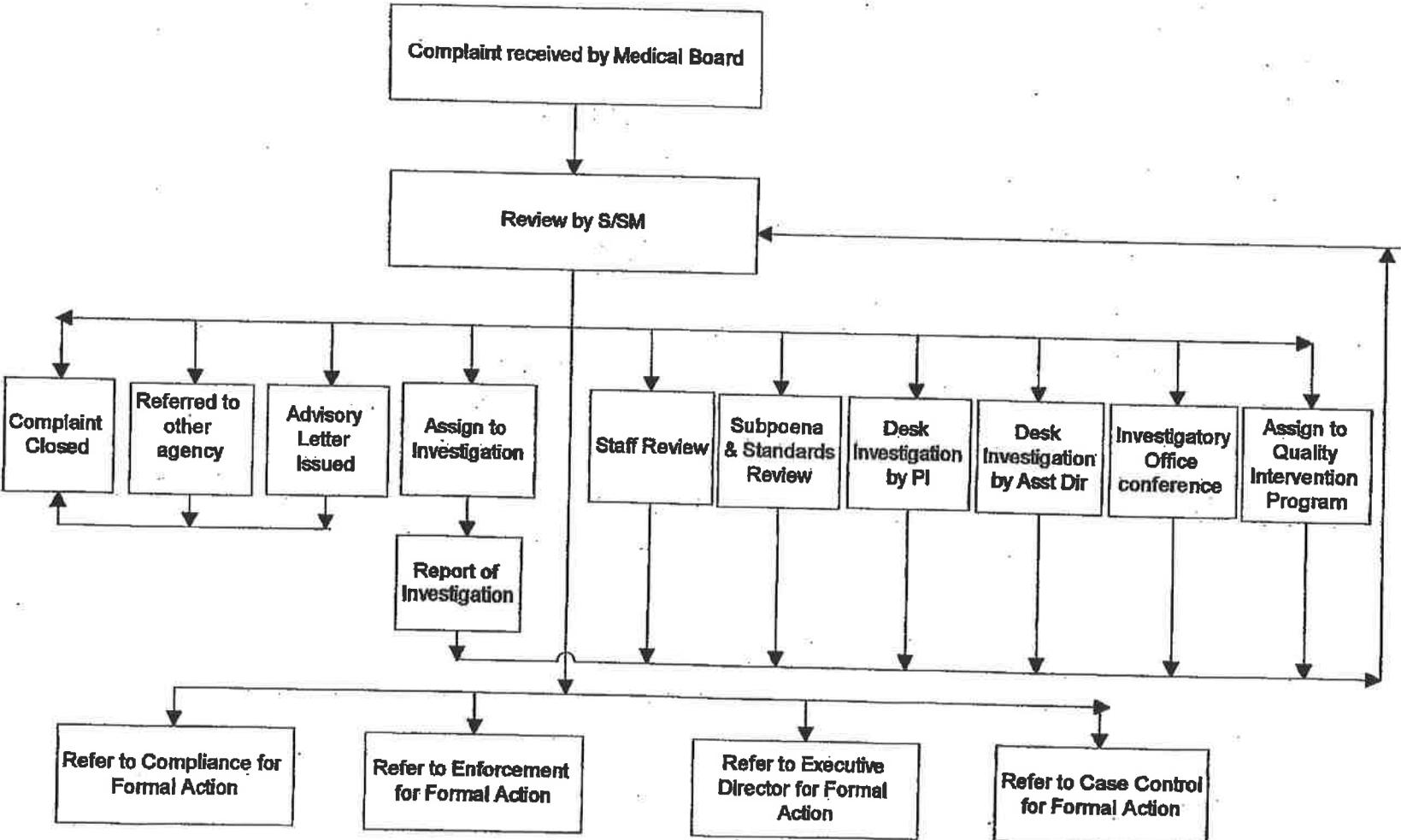
Thank you for your letter of June 11, 1996, a copy of which is attached.

As we discussed, please refer to my letters to Dr. Gretter dated April 19 and April 30, 1996. I appreciate your help in this matter.

Sincerely,

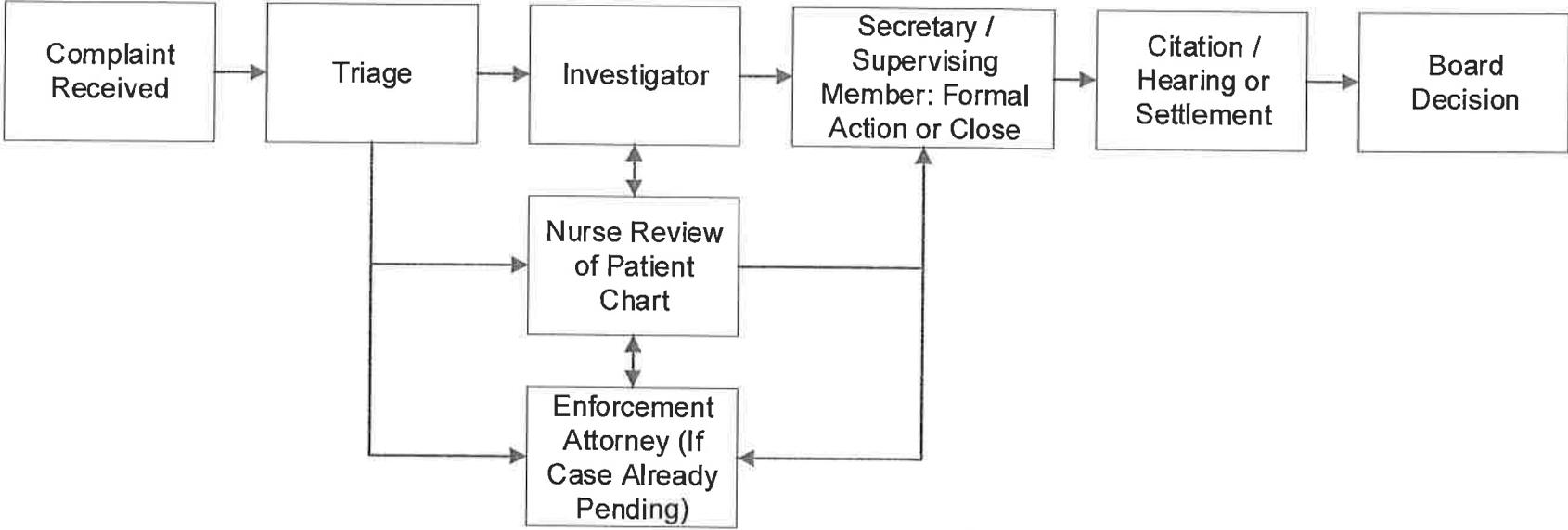
Richard H Strauss
Richard H. Strauss, M.D.

Standard Complaint Process

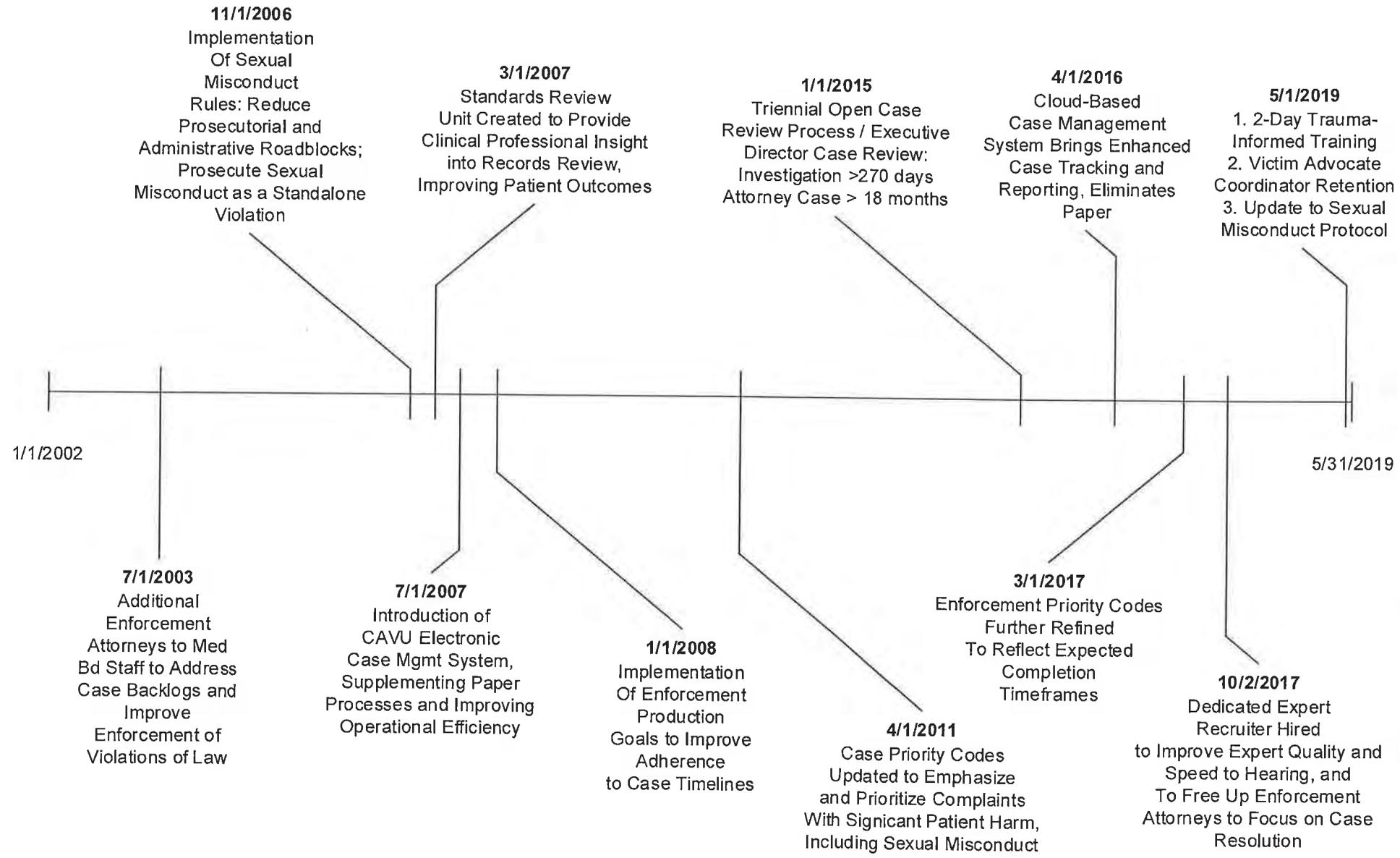


Revised 11/99

State Medical Board of Ohio
Sexual Misconduct Investigation Process - 2019



State Medical Board of Ohio Sexual Improprieties Investigation Milestones





**Minutes from the May 23, 2019
Special Meeting of the State Medical Board of Ohio**

Pursuant to Ohio Revised Code 121.22(F), the State Medical Board came to order for a special meeting on Thursday, May 23. Acting president, Dr. Michael Schottenstein called the meeting to order at 11:30 a.m. with the following members present: Dr. Rothermel, Mr. Giacalone, Dr. Schottenstein, Mr. Gonidakis, Dr. Feibel, and Dr. Bechtel.

Dr. Bechtel made a motion to go into executive session to consult with the board's attorneys concerning disputes involving the medical board that are the subject of pending or imminent court action. Dr. Rothermel seconded the motion. All board members voted aye, and the motion passed.

Executive session began at 11:31 a.m. and ended at 12:15 p.m.

DISCUSSION ON WAIVER OF CONFIDENTIALITY: (F)(5)

Dr. Schottenstein stated: under the case law interpreting Section 4731.22(F)(5), several parties have confidentiality rights in the Board's investigative files, including patients, complainants, the licensee, and the Board itself. This confidentiality protects sensitive patient information from being inappropriately released to the public. Investigative information protected under section 4731.22(F)(5) may be released to another governmental agency only if that agency is conducting an investigation of a violation of laws and rules. In December 2018, the State Medical Board of Ohio provided a copy of its investigative file regarding Richard Strauss, M.D. to Ohio State University as a governmental agency conducting an investigation of a violation of laws and rules. The investigative file provided to Ohio State University was unredacted, with the exception of any social security numbers included in the file. The statute requires that the governmental agency in receipt of the board's investigative materials must keep the information confidential in the same manner as the Medical Board is required to do. Ohio State University has indicated that some individuals with a confidentiality interest have waived that interest and has asked if the Medical Board would consider waiving its confidentiality interest in the investigative materials.

Dr. Bechtel made a motion to waive the Medical Board's confidentiality interest in the investigative materials involving Richard Strauss, M.D. Mr. Gonidakis provided a second on the motion.

Mr. Giacalone stated that along with the board's motion to waive confidentiality, we urge OSU to complete the information needed for their report, to provide some closure needed by the individuals and their families who have been affected by this event.

Dr. Schottenstein stated that the Medical Board released the entire unredacted file to Ohio State. This conversation is about releasing it to the public; and the irony is that nobody wants to release the Strauss

file to the public more than the Medical Board. Not just because it is undeniably in the board's self-interest to release this file, because it clearly is, but to give the victims of this perpetrator some peace. As a rule, we value transparency, which is why all our proceedings occur in the public setting. Dr. Schottenstein thought it was frustrating for the board members and staff; that we felt an obligation to do our best to uphold the law, the F5 statute which makes medical board investigations confidential. Regrettably, if the board were to simply release the Strauss file to the public, it would likely have a chilling effect on the public's confidence in coming forward with complaints. Right now, people know they can bring a complaint, and they will have absolute confidentiality. Dr. Schottenstein stated that it is important for patients and whistleblowers to know that this is the case. If doubt about confidentiality creeps in then the public will stop coming forward with their concerns, and that will negatively impact the board's ability to protect the public.

Dr. Schottenstein continued: If he had been in the audience when the governor gave his press conference, he would have applauded him because he appreciates the governor's leadership, and because he is grateful for the work group review. As the governor said, even though it was 23 years ago, it is important to know if something went wrong with the medical board's processes. It's important to make sure that the board has rectified any failures in those processes. Our common goal is to protect the citizens of Ohio; anything that can further that goal is very much appreciated. Dr. Schottenstein is cautiously optimistic that the public would appreciate the current board's approach to sexual misconduct complaints. Every sexual misconduct complaint is automatically assigned our highest priority and is thoroughly investigated. The board has strong rules pertaining to sexual misconduct that it did not have 23 years ago. And staff receives specific training in this area as well, but he would welcome the sunlight that a work group investigation will bring and would welcome any additional suggestions and recommendations for how the board can do its job better. Dr. Schottenstein's heart breaks for the victims of this perpetrator. Words really cannot describe how horrified he has been about this. He is also grateful to Ohio State, for doing their best to be open and thorough and transparent. At the end of the day, everybody's on the same team. The board wants this information out there. It wants to make sure that this never happens again. The only question has been how to get there. So, when Ohio State came forward recently with their idea about individual complainants waiving their confidentiality, so that those aspects of the file could be released, he was grateful for that. Dr. Schottenstein's strong recommendation was that the board vote to approve the waiver of its confidentiality as allowed under the law.

Dr. Bechtel made a motion to waive the Medical Board's confidentiality interest in the investigative materials involving Richard Strauss, M.D. with protections for individuals who have not waived their confidentiality. Mr. Gonidakis provided a second on the motion.

Roll call vote:

- Dr. Rothermel- yes
- Dr. Feibel- yes
- Mr. Giacalone- yes
- Dr. Schottenstein- yes
- Mr. Gonidakis- yes
- Dr. Bechtel- yes

The motion passed with six yes votes and zero no votes.

Dr. Bechtel made a motion to adjourn. Mr. Gonidakis provided a second. A vote was taken, and all board members voted aye. The motion carried. The meeting was adjourned at 12:21 p.m.

We hereby attest that these are the true and accurate approved minutes of the State medical Board of Ohio special meeting on May 23, 2019 as approved on July 10, 2019.



Michael Schottenstein, M.D., President



Kim G. Rothermel, M.D., Secretary

