Part 1:
Medical Problems

Chapter 1

No state inspections for these types of facility are held in: Alaska, Colorado, Hawaii, Idaho, Iowa, Maine, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia.

Inspections are held in New York, but what violations were found and at which location are heavily redacted and therefore not available to the public.

California investigates individual complaints but does not do full health inspections. Therefore, many of the health department documents contain nothing other than privacy complaints, and those are covered in Chapter 8 on Privacy.

There are no Planned Parenthood centers in North Dakota or Wyoming

Alabama

Birmingham

The health department documents from 2009, 2013, 2014, 2016, and 2021 can be found at:

www.problemsatplannedparenthood.org/alabama

Highlights:

Clinic Conditions

- The clinic failed to ensure staff cleaned equipment used in surgery, nor clean chairs in the recovery room, nor wash their hands.
- An examination table was in disrepair, increasing the chance of infection.

Staff

- There was no policy to ensure that doctors were competent and qualified, such as observation of surgical procedures and interactions with patients.
- The medical director failed to document an annual review of competency for two doctors on staff.
- There was no job description on record for the Health Center Manager.
- Four medical employees had no record of a Hepatitis B vaccine or a TB test. There was also no record of a nurse practitioner being screened for hepatitis.

Medical Records and Labels

- Paperwork given to women before surgery failed to include the names of medications given, what medications were to be taken home, and omitted the name of the doctor operating on them.

Incidents

- In 2014, two employees sold drugs to patients in the parking lot. The director fired all staff. To hire and train new staff, the facility was closed, but the director never informed the Health Department of the closure. None of the former employees cooperated with health inspectors.

Other

- The telephone number of the Alabama Department of Public Health complaint hotline was neither posted where patients could see it, nor given in the patient instructions.

Mobile

The health department documents from 2011, 2014, 2016, and 2021 can be found at:

www.problemsatplannedparenthood.org/alabama

Highlights:

Clinic Conditions

- Some of the emergency medications were missing.
- The Emergency Kit wasn't secured.
- Expired medications were used on patients.
- The clinic failed to conduct preventative maintenance on medical equipment.
- Staff failed to inspect all four fire extinguishers on a monthly basis.

Staff

- Doctors and workers were observed failing to wash their hands after conducting medical tasks and before handling sterile instruments.

Medical Records and Labels

- The clinic failed to document post-surgical pathology results. Any material left after surgery can cause severe infection.
- Many records were incomplete, including documentation regarding ultrasounds and anesthesia.
- The nurse failed to document what medications were given, or at what times..

Incidents

- On March 3, 2011, a patient who'd been given medication called to report "severe cramping and uncontrollable bleeding." There was no record of instructions given nor any follow-up phone calls to monitor her condition.
- Clinic staff failed to report the possible sexual abuse of a minor. A 14-year-old girl with two living children came in for an abortion on April 12, 2014, then came in for a second abortion on November 18, 2014. Although this minor had been pregnant four times in a short period of time, no report was filed.
- In one patient's case, a pathology examination revealed no tissue was obtained. The facility didn't notify the patient, who went to see a doctor because of abdominal pain, without the needed information.
- One patient was given medication even though tests showed her hemoglobin level was under 10, indicating anemia. This put her at risk of complications.
- Twelve patients weren't given the name of the doctor who did surgery on them and didn't have the needed contact information in case of complications.

Arkansas

Little Rock

The health Department documents from 2016 and 2018 can be found at:

www.problemsatplannedparenthood.org/arkansas

Highlights:

Clinic Conditions

- Items required for patient care weren't stored in a clean environment. For example, white drapes used in exams were left on the floor of the storage room. The clinic was cited for allowing the contamination of patient care equipment.
- The facility "failed to ensure that equipment was kept in good repair."
- A stool in the ultrasound room had a cloth covering which "has an absorbent nature and cannot be disinfected." A hole in the covering extended down into the cushion.

Other

- The clinic failed to "develop, implement, or rehearse" plans for what to do in case of a disaster.
- The facility was required to make available a list of emergency phone numbers and contact information for police, the fire department, ambulance services, and other emergency responders. The list hadn't been updated in two years. This could cause a delay in contacting emergency.

Arizona

Flagstaff

The health department document from 2016 can be found at:

www.problemsatplannedparenthood.org/arizona

Highlights:

- The facility failed to properly sterilize instruments and textiles that "may come in contact with a patients' blood and internal tissue." Using unsterilized, dirty instruments on multiple women has the potential to spread infection.

Glendale

The health department documents from 2015 and 2020 can be found at:

www.problemsatplannedparenthood.org/arizona

Highlights:

Clinic Conditions

- The facility used expired medications on patients. Some were two years past their expiration dates.
- Staff failed to perform required spore tests on the autoclaves (machines used to sterilize instruments). This could lead to "a potential risk of cross contamination and infection to their patients" according to the report.
- Staff failed to properly maintain, clean, and sterilize the autoclaves as per the manufacturer's instructions. There was no documentation that the autoclaves were cleaned on a weekly or even monthly basis.
- When blood dripped from a used speculum onto the floor, staff was observed wiping it up with paper towels and cleaning spray rather than using bleach and properly disinfecting the floor.
- Hazardous chemicals weren't properly labeled.
- Staff didn't properly clean and disinfect post-procedure specimen bottles.
- Staff failed to clean and sanitize examination tables between patients.
- According to the report, these omissions, "have the potential for non-sterile instruments or non-disinfected supplies to be utilized on patients."
- There was no designated infection control person assigned to the infection control position, no one whose job is specifically to ensure that cleanliness and proper sterilization practices were followed.
- There were multiple tears and punctures in the upholstered material of an examination table, exposing stuffing. This presents an infection risk as it makes the surface difficult or impossible to properly disinfect.

Staff

- Three staff members had not received yearly TB tests, and the test of another was improperly conducted, rendering it invalid.
- Two doctors weren't certified in CPR. There was no documentation of present or past certification.

Privacy

- A HIPAA (privacy) violation that occurred at the clinic wasn't documented.

Incidents

- A patient had an adverse reaction to sedation administered before a procedure. She suffered severely low blood pressure. This wasn't reported to the medical director or recorded in the procedure notes. The RN who administered the sedation wasn't licensed to do so. When asked to show what protocols were in place for treating patients suffering severe hypotension (dangerously low blood pressure) the clinic was unable to provide any. The facility also had no guidelines for what blood pressure measurements indicated severe hypotension. According to the report, the center manager "verified, during an interview conducted on 2/13/15, that there are no established blood pressure parameters for severe hypotension, standing orders, and/or facility policy that identifies the care and treatment of a patient experiencing severe hypotension after adversely reacting to a medication provided for conscious sedation."

Tempe

The health department documents from 2014 can be found at:

www.problemsatplannedparenthood.org/arizona

Highlights:

Clinic Conditions

- Didn't have a policy for the use, cleaning, and preventive maintenance of certain equipment used on patients, such as heating pads.
- The facility appeared to be using irrigation solution (Braun 0.9% Sodium Chloride) that, by manufacturer's standards, should've been discarded.
- The autoclave, used to sterilize the instruments, was required to be cleaned weekly. However, the last documented cleaning was nearly three months prior to the inspection. Staff couldn't verify the autoclave had been cleaned more recently than that.
- The clinic staff failed to monitor how many cycles the autoclave was running. This was supposed to be done automatically by a printout attached to the machine. However, the paper in the printer had run out and hadn't been replaced.

California

Antioch

The health department document from 2016 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

Staff

- Unlicensed and untrained staff were seeing patients and giving medical care.
- Employees were counseling patients, giving medical advice, examining patients, and obtaining informed consent even though they weren't qualified to do so.
- The staff member who performed vaginal ultrasounds was untrained and unqualified, with only a high school diploma with one medical assistant class. From the report "the performance of a transvaginal ultrasound is an invasive procedure which could potentially result in patient."
- The medical director stated the only requirement in hiring an ultrasound technician was a high school diploma.
- The head of ultrasound training wasn't a certified ultrasound technician.
- According to the medical director, all 20 clinics she supervised employed untrained ultrasound technicians who were merely certified as medical assistants. The director stated she felt medical assistants were qualified to do ultrasounds but was unable to give an example of a health care facility, other than her clinics, where they were doing so.

Incident

A woman suffered a severe complication, and the clinic failed to cooperate with investigators as to the incident. Surveyors were turned away twice and not permitted to inspect the facility. Clinic staff refused to allow inspectors access to the patient records, refused to allow inspectors entry into the facility, and when they did allow investigators access to electronic records, refused to let them make copies or take notes.
The patient later began bleeding heavily and passed large clots, one of which was the size of a baseball. She passed out and went to the hospital. The patient later said, "I could have died." She needed surgery and a blood transfusion.

The nurse who gave the patient medications wasn't licensed to do so and failed to follow clinic protocol. She gave the patient three extra medications.

Orange

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

- One patient suffered copious bleeding after surgery and was sent to the hospital to be treated for complications and blood loss. Staff failed to properly document the incident in their records.
- A second patient also bled heavily after surgery. She was sent home with active bleeding after passing a large blood clot. It was estimated from her hemoglobin level that she lost 720 ml of blood. The clinic failed to document the amount of blood loss in their records.

San Jose

Doctor's License Revoked – Joplin

Dr. Joplin served at Planned Parenthood, primarily at the San Jose Center, for many years and was working there at the time of his license revocation in 2011. The full license orders from 2011 and a previous one from 1997 can be found at:

www.problemsatplannedparenthood.org/california-san-jose

from 2011 license document:

8. . . . it was alleged that Respondent engaged in unprofessional conduct in that he consumed alcohol to excess and to an extent he endangered himself and others, and that he had been criminally convicted on two separate occasions of offenses related to the use and consumption of alcohol . . . Respondent's license was revoked, stayed, with seven years probation. The terms and conditions of probation . . . required him to abstain completely from the use of products or beverages containing alcohol, submit to biological fluid testing, undergo a psychiatric evaluation, participate in psychotherapy, have a practice monitor, and not engage in the sole practice of medicine . . .

9.A. . . . Respondent failed to comply with this term of his probation in that multiple bodily fluid tests resulted in a positive test result for the presence of alcohol.

Excerpts from 1997 license document:

First Cause for Disciplinary Action

E. Y.G. had a normal prenatal course until on or about March 28, 1990 . . .

11.G. Despite elevated blood pressure, proteinuria and other findings on examination, respondent did not consider and/or did not chart the possibility of preeclampsia, did not consider and/or did not chart the potential for early induction of labor in Y.G. and did not conduct appropriate patient surveillance. . .

11.I. Four days later, on April 9, 2990, Y.G. presented to the Emergency Room at South Valley Hospital with complaints of severe acute low back pain. . . . Y.G. was diagnosed with toxemia. Emergent medical measures were taken. After delivering a viable male infant, Y.G. died on April 10, 1990.

12 . . . he is guilty of gross negligence and/or incompetence in the practice of his profession . . .

Second Cause for Disciplinary Action

13.B. On July 17, 1993, patient M.M. presented to respondent for examination at the Planned Parenthood Clinic in Seaside, California . . . Respondent recorded in the chart that the patient was 9 and ½ weeks pregnant. Respondent preformed a pelvic examination at that time and recorded that the uterus was soft and felt approximately 11-12 weeks size . . .

13.C. On July 17, 1993, respondent undertook to perform an abortion . . .

13.D. Respondent ordered M.M. transferred to Natividad Medical Center, Where ultrasound demonstrated the fetus to be 27 weeks. Labor was induced and the female stillborn was taken for evaluation by the County Coroner.

13.E. At all relevant times, respondent knew, or in the exercise of reasonable care should have known, that M.M.'s fetus was 27 weeks and viable.

14. . . . he is guilty of gross negligence and/or incompetence . . .

Ventura

The health department document from 2013 can be found at:

www.problemsatplannedparenthood.org/california-s- to-z

Highlights:

A 23-year-old woman, after surgery, began to bleed heavily. The staff unsuccessfully administered medicine to stop the bleeding, then called 911. According to paramedics, the woman was "confused with slurred speech." Her blood pressure was dangerously low.

At the hospital, the woman was said to be in "severe distress" and "hemorrhagic shock." The woman was given a "massive transfusion" and taken into surgery. Surgeons found that the doctor had perforated her uterus. A hysterectomy was done, and the patient permanently lost her ability to have children at 23.

Though legally required to, the clinic failed to report the complication to the California Department of Health; it only came to light with an anonymous tip. Clinic staff claimed they were "unaware" complications needed to be reported, implying they never reported complications to the Department of Health.

Connecticut

Bridgeport

The below is taken from a video of testimony before the Connecticut House of Representatives by Connecticut state representative Treneé McGee (D), April 19, 2022. The video can be found at:

www.problemsatplannedparenthood.org/connecticut

Excerpt:

The matter of Black life began for me when I talked to a young woman . . . She got a pill [from Planned Parenthood in Bridgeport] . . . And three days later she could not walk. She landed in the hospital . . . And she then had an infection behind her uterus. She needed a blood transfusion. And she relearned how to walk which it took her a month to do . . . She didn't have the resources to pursue a case.

Hartford

The health department document from 2016 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlight:

The clinic failed to have needed emergency supplies.

New Haven

The health department documents from 2015 and 2018 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- The autoclave, used to sterilize instruments, had not been cleaned for three months. The clinic manager was "not sure" why it hadn't been cleaned.
- According to the inspection, "the facility failed to ensure that infection control practices were maintained." The sterilization logs didn't document the results of the steam indicator placed in each load of sterilized instruments.

- Medications were stored in a refrigerator with cans of ginger ale for the staff.
- Chairs in the recovery room were cloth-covered, meaning that they couldn't be properly sterilized or cleaned.
- Prefilled syringes weren't labeled with the dates and times filled, the initials of the staff member who filled them, and the doses.

Staff

- The staff didn't properly clean instruments. Staff failed to mix the solution for cleaning instruments properly. Staff didn't measure the amount of detergent to mix with water but estimated instead. They didn't follow the manufacturer's instructions to ensure a strong enough solution to properly clean the instruments.

Medical Records and Labels

- The times medications were given and the staff giving them weren't recorded.
- In a subsequent inspection, records were also incorrect.

Incidents

- Before one woman's procedure, a nurse noted no drug allergies. However, her later records showed that she was allergic to a Keflex. Fortunately, the woman didn't suffer complications or a drug reaction, but the inconsistency in charts could've presented a risk.

Treatment of Patients

- Single-use intravenous fluids were used on multiple patients.
- Opened medications weren't properly labeled and didn't have expiration dates, leading to the use of expired medications on patients.

Norwich

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- Bags of soiled laundry, likely stained with bodily fluids, were stored in a post-anesthesia care area. Clinic staff admitted that the bags had been there for five days.

- Instruments required to be sterile were stored in the dirty decontamination area, along with multiple boxes, supplies, and equipment.
- The emergency light fixture in the staff bathroom wasn't working, nor the emergency light fixture in the waiting area. This was a violation of the fire code.
- Fire alarms and smoke detectors weren't regularly tested.

Staff

- Staff members didn't have the proper medical credentials.

Medical Records and Labels

- Sterilization logs were missing patient information. Instruments used on different women, therefore, weren't tracked to maintain proper infection control.
- Records for one patient failed to indicate that a comprehensive medical assessment was performed before surgery. Clinic staff claimed that one was performed but was not recorded due to a new computer system.

Torrington

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- According to the inspection report, "the facility staff failed to follow acceptable infection control practices."

Medical Records and Labels

- An open multi-use vial of medication wasn't marked with the date it was opened or with the discard date. Another vial was missing the discard date. This meant that clinic staff didn't know when to discard these vials and risked giving expired medicine to women.

Waterbury

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlights:

- Medications and hepatitis vaccines were stored in the dirty utility room along with used, soiled instruments. This included an open, half-empty, multi-use vial of an injectable drug stored in a refrigerator. There was no documentation on the vial of when it was opened or when it should be discarded.
- The medication refrigerator was located under the sink in the dirty utility room where dirty instruments were washed.
- Blood samples were stored with medication in the refrigerator in the dirty utility room. According to the report, these blood samples "failed to be stored in a tightly sealed container in the refrigerator."

West Hartford

The health department document from 2015 and 2018 can be found at:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- Test strips are included with each load of instruments sterilized in the autoclaves. One of these test strips indicated a load was not properly sterilized. However, there was no indication in the records that these instruments were subsequently reloaded into another autoclave and sterilized again, as per proper procedure.
- The facility had cloth-covered chairs in the recovery room. These chairs couldn't be properly sterilized or cleaned.
- A cloth pillow in the procedure room wasn't cleaned between patients. The clinic failed to use disposable covers for the pillow and reused the same pillow.
- The clinic failed to test and maintain fire alarms and sprinklers.

Staff

- A staff member failed to wash her hands before preparing the procedure room for a patient.

Medical Records and Labels

- Staff repeatedly failed to document whether test strips indicated that instruments were properly sterilized. (See above)
- Medical records were incomplete. The times that medications were given to patients weren't documented, and neither were the names of the staff members giving medications.

- There was a discrepancy in the records about the type of sedation one patient received. One set of records indicated she received intravenous moderate sedation but failed to mention the medication given. The other record indicated fentanyl and Versed were given.

Treatment of Patients

- IV fluids meant to be single-use were reused for multiple patients.

Other

- The staff failed to conduct fire drills and emergency preparedness training.
- The cabinet containing narcotics was left unlocked and unattended.

Delaware

See documents from the Delaware Board of Medical Licensure, a Complaint and an Order, for Dr. Liveright, who worked at Planned Parenthood and gave up his license in 2013. See also full testimony and a letter excerpted below from nurses at:

www.problemsatplannedparenthood.org/delaware

Excerpt from Testimony to the Delaware State Legislature by Nurse Mitchell-Werbrich:

On April 20, 2012, I was hired as a recovery room nurse at Planned Parenthood of Delaware. I worked a total of 27 days (approximately) at Planned Parenthood. I worked 16 days at Planned Parenthood of Delaware's Wilmington site and 11 days at Planned Parenthood of Delaware's Dover site. I was forced to resign on August 8, 2012 as the conditions at Planned Parenthood continued to be unsafe and potentially life-threatening for the . . . I feared that a patient was going to end up being harmed and that I would lose my nursing license. I also endured a hostile environment at Planned Parenthood after reporting the horrendous conditions that were occurring there . . .

I witnessed meat market style assembly line abortions. This type of care was something I had never seen before in my entire nursing career. On an average day at the Wilmington Planned Parenthood site one abortion would be completed every 8-10 minutes. The doctor would be in such a hurry to get the patients in and out that he himself would bring the patients back into the unclean procedure room where the examination table would still have bloody drainage and body fluids on it from the previous patient . . .

Another very serious concern I had at Planned Parenthood was the mishandlings of RhoGAM. RhoGAM is a product that must be given within 72 hours to every . . patient whose Rh factor is negative after having an abortion. . . I cannot help but think of

all the Rh negative women that may be suffering from not having the RhoGAM they needed. It is likely that many women in Delaware may have to deal with future babies who have severe anemia, jaundice, brain damage, heart failure or even death. The sad thing is that these women may not even realizeo the fact that Planned Parenthood could be at fault for these medical tragedies even years after they had their abortions at Planned Parenthood . . .

I witnessed that the emergency box and equipment contained expired emergency medications as well as faulty emergency equipment such as an oxygen mask that was no longer functional. This could potentially cause death to a patient in need of emergency care . . .

I had reported to both of these state agencies the many unsafe conditions which included that there were no guidelines, no standards of care, no procedure, or protocol manuals to be found anywhere, intravenous (IV's) were being started using an unsterile technique and patients endured multiple needle sticks. I reported that Planned Parenthood's Dr. Timothy Liveright had struck a patient by inappropriately slapping her at the dilation phase during an abortion. I reported that most of the Planned Parenthood Staff members did not wear protective gear or utilize universal blood and body fluid precautions; consents for sedation and procedures were sometimes obtained late as staff was rushed and hurried; registered nurses had to hide the patient's chart from Planned Parenthood's Dr. Timothy Liveright so the pre-procedure medications could have time to take effect because he was in such a rush to get to the next patient; lab work not being performed correctly thus the lab value results were incorrect; patients given sedation were found outside walking down Market Street dazed and confused; staff medical credentials were not verified; the emergency medications and equipment had expired; the narcotics were not being regulated; HIPPA privacy not being practiced; an intern who had been instructed by her instructor to only observe was pressured into providing abortion care; Planned Parenthood's Dr. Timothy Liveright once left sedated patients in the middle of an abortion procedure waiting for hours in order to handle a mechanical issue with his private airplane; and more . . .

Ms. Peterson also informed me that she could only take complaints from patients. I told her that this patient population was not at all likely to report to her. I explained to Ms. Peterson that abortion is a stigmatizing event that causes patients to feel too uncomfortable to advocate for themselves. I also shared with Ms. Peterson that many of the patients that receive care at Planned Parenthood are young, poor, often minorities that lack knowledge of the reporting process to Delaware Health and Social Services and that these patients generally do not have the financial means to hire legal assistance necessary to even defend themselves. I told her that I was reporting on behalf of the patients and to consider me to be the "voice of the patients." But Ms. Peterson refused again stating that she could only take complaints from a patient.

Excerpt from Nurse Mitchell letter:

Often Dr. Liveright starts his day by wearing a scrub uniform that is wrinkled and stained with what appears to be bloody drainage. His personal hygiene is unprofessional as well.

When starting an IV, Dr. Liveright uses the same needle for multiple sticks. This is not proper medical procedure.

Media articles:

Planned Parenthood Doctor Gave Up Delaware License
by Kara Nuzback, *Cape Gazette*, June 3, 2013

Complaint Filed Against Planned Parenthood Abortion Doc
Channel 10, Philadelphia May 30, 2013

Excerpt:

State medical licensing officials filed a formal complaint Thursday against a doctor who performed abortions at a Planned Parenthood clinic in Wilmington that was recently cited by public health officials for several unsafe and unsanitary practices.

The complaint by the state Board of Medical Licensure and Discipline said Dr. Timothy F. Liveright represents a "clear and immediate danger to the public."

It accuses him of engaging in multiple acts of incompetence and negligence in performing abortions on five patients in February and March of this year.

Those acts, according to state officials, include oversedating patients, performing unnecessary suction procedures, causing at least one perforation during surgery, and failing to act with proper competence and diligence to avoid unnecessary complications that resulted in patients requiring emergency hospital treatment.

The complaint also notes that Liveright was reprimanded by Planned Parenthood in March of last year for unprofessional conduct that included sexually harassing female employees and ``yelling, screaming, and cursing'' in front of patients and employees.

Nurses Claim Wilmington Planned Parenthood Never Notified Women of STDs
by Tim Furlong and David Chang, Channel 10, Philadelphia, July 30, 2013

Excerpt:

A Planned Parenthood facility in Wilmington is under fire following new accusations from three former employees.

Former manager Melody Meanor and former nurses Joyce Vasikonis and Jayne Mitchell-Werbrich spoke at a legislative hearing on Monday, claiming the Planned Parenthood clinic located on Shipley Street in Wilmington is unprofessional, under-trained and unsafe.

“Women are exposed to potential infection of any kind you can imagine that can be passed from one patient to another,” Vasikonis said.

During their testimony, the women claimed the privacy of patients was jeopardized, that they were asked to falsify employee records, that medical assistants were poorly trained and that certain women in need of certain medications after abortions often didn’t receive them. They also claimed that the facility failed to inform up to 200 women that they tested positive for gonorrhea and chlamydia.

Florida

Some of the health department documents only list that the facility failed to provide a phone number to report complaints or that the license wasn't posted, and those aren't included here, but are on the Florida page on the website.

Pembroke

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/florida

Highlights:

- Staff performed surgery for which the clinic wasn't licensed.
- There were no logs or records for tracking the disposal of biological waste.

St. Petersburg

The health department documents form 2013, 2015, and 2017 can be found at:

www.problemsatplannedparenthood.org/florida

Excerpt:

"The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (1) Water quality. (2) Temperature. (3) Humidity. (4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This standard is not met."

Sarasota

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/florida

Highlights:

Clinic Conditions

- The facility failed to regularly clean and test the autoclaves as per the manufacturer's instructions. Autoclaves are used to sterilize instruments that are used on multiple women. There were no logs or any other records documenting the times and dates when the autoclaves were to be cleaned. Autoclaves were required to be cleaned weekly; instead, they were not cleaned for months.

Indiana

Bloomington

The health department documents from 2017, 2018, and 2019 can be found at:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- According to inspectors, the facility "failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients."
- Human blood from blood tests wasn't handled in a safe and sanitary manner, risking the spread of blood-borne infections such as HIV and hepatitis. Blood was stored with medications in the refrigerator. Blood tests for Rh factors were conducted on the same countertop used to prepare medications and blood drops from these tests were in close proximity to pregnancy tests. This was noted in multiple inspections.
- Medication was stored on the same countertop where tests were done on urine and blood. This was an ongoing problem cited in two inspections.
- The clinic's backup generator wasn't given regular maintenance.
- Other equipment, such as the two autoclaves used to sterilize instruments, weren't adequately inspected and maintained. The autoclaves, exam lights, and exam tables weren't examined for electrical current leakage.
- The clinic had (and appeared to be using) expired medication.

- An oxygen tank was stored improperly and, according to the report, “could create a source of a potential hazard to patients, visitors, or employees.”
- The facility failed to document (and possibly conduct) proper maintenance of equipment such as a defibrillator, emergency call system, recovery chairs, vacuum units, and procedure tables.
- Documents indicated that the telephone intercom system wasn’t working, and there was no indication it was fixed.
- Staff failed to document (and possibly perform) the cleaning and disinfection of exam rooms, labs, and equipment and weren’t properly trained to do so.

Staff

- The facility failed to have a policy to evaluate, test, and improve the skills of nurses, lab technicians, and other staff members. The clinic failed to review and evaluate nursing services, laundry services, medical record review services, maintenance services, or laboratory services. This was cited in multiple inspections.
- Staff failed to wash their hands after handling linens that were soiled with bodily fluids. No sink or handwashing facilities were present in the room where laundry was washed and handled.
- Staff wasn’t trained to use the backup generator and no training manuals were available.
- The clinic didn’t have someone “qualified by training or experience” responsible for supervising infection control and making sure proper procedures were implemented and followed.
- Staff didn’t have proper training in cleaning and disinfecting instruments, equipment, and exam rooms.

Medical Records and Labels

- The clinic failed to maintain accurate medical records, neglecting to record patient condition at discharge, transfers to hospitals of injured patients, procedures performed, and other data. All three inspections found that proper medical records weren’t kept, indicating an ongoing problem.
- One inspection found that laboratory results weren’t documented. For example, Rh testing results were neglected to be recorded. If these tests weren’t performed (and we have no way of knowing whether they were, without documentation) and the clinic, therefore, neglected to administer RhoGAM, future pregnancies of women were put at risk. Rh sensitization can cause miscarriages and damage babies in subsequent pregnancies. Also not recorded were pre-abortion pelvic exams.
- Staff repeatedly failed to sign paperwork. This was an ongoing problem, cited in two different inspections.

Treatment of Patients

- The facility failed to monitor patients' vital signs while they were in the recovery room after surgery. The clinic didn't monitor or record blood pressure, respiratory rate, and/or pulse of women post-surgery. This was true of all 22 patients whose records were examined. This was an ongoing problem; the clinic was cited for it in all three inspections.
- The clinic lacked the policy to ensure that medical histories were taken promptly and proper physical examinations were performed.

Other

- The facility didn't have a quality assurance program to oversee and evaluate emergencies, infection control, patient complaints, safety, and competence.
- There were no training manuals to teach clinic staff how to operate equipment. This was not corrected and was found to be the case in more than one inspection. There were no user manuals for the emergency call system.
- The clinic failed to regularly evaluate the care given to patients.
- Controlled substances were unsecured and could be accessed by unauthorized persons, such as patients and staff.

Indianapolis
(health department)

The health department documents from 2012, 2014, 2017, 2018, and 2019 can be found at:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- An oxygen tank was left unsecured standing upright in a room. According to the report "if the tank was knocked over and broke the head off the compressed cylinder, it could cause harm to people and/or property."
- Regular preventative maintenance wasn't conducted on the emergency call system, presenting a potential risk in the case of an emergency. Regular maintenance was also not conducted on a wheelchair.
- Emergency defibrillators weren't tested or properly maintained.
- Although the facility gave IV sedation, it had no cardiac monitors available.
- The facility failed to change the disinfection solution used to sanitize the procedure room as per the manufacturer's guidelines.

- The facility used expired test strips to test whether Cidex, a sterilization fluid, was of good enough quality to be effective.
- There was trash in the clinic parking lot, presenting a habitat and breeding ground for pests such as rodents and insects.
- There were expired emergency supplies, including IV bags.
- The facility failed to maintain 5 out of 7 pieces of equipment, including smoke detectors and an emergency generator. In a subsequent inspection, 11 of 12 pieces of equipment weren't properly maintained.
- The facility failed to perform regular maintenance on emergency and other equipment. This included the cardiac monitor, defibrillator, suction machine, emergency call system, sterilizer, exam light, and wheelchair. This was cited in more than one inspection.
- The facility failed to test the defibrillator to ensure it was in working order.
- Electric current leakage checks weren't performed on equipment.
- The facility failed to properly clean and sterilize the vaginal ultrasound probe.
- There were no monthly checks of medications, equipment, and supplies.
- Clinic staff failed to verify that blood specimens for Rh testing were stored at appropriate temperatures, which may compromise the integrity of the tests. Records indicated these specimens were stored at inappropriate temperatures, and this wasn't addressed or fixed promptly, rendering the tests unreliable. Failure to detect and treat Rh compatibility problems can lead to miscarriage or infant death and negative outcomes in future pregnancies.

Staff

- The clinic didn't conduct or document a proper orientation for new employees.
- Two out of four doctors (one half) and one health care assistant weren't trained in CPR and would not have been able to perform CPR in an emergency. In a subsequent inspection, a medical assistant and the medical director were found not to have CPR certification. This was an ongoing problem.
- The clinic had no designated person with prescriptive authority and no one in control of drug stocks.
- The clinic didn't verify staff immunizations and failed to provide hepatitis B vaccines to two employees who requested them. The clinic also knowingly employed several staff members who weren't vaccinated, despite having a written policy not to do so.

Medical Records and Labels

- Medical records were incomplete with missing information. Some of the things the clinic staff failed to document were whether ultrasound was used when needed for surgery, whether the patient had used drugs or alcohol before the procedure, whether the airway was maintained for patients receiving sedation, and whether there were complications. Medical histories were incomplete, with no documentation of women's health conditions that could affect the safety of procedures. In some cases, the type of anesthesia given to patients and whether

they received sedation wasn't documented. Start and stop times of procedures weren't documented. Doctors failed to sign paperwork.

Incidents

- One patient who received versed and fentanyl had her oxygen saturation level drop to 76% during her surgery. Despite this dangerously low oxygen saturation level, no supplemental oxygen was given. There was no documentation in her chart of any intervention or medical treatment given for this medical crisis. The director and staff who were interviewed said they "didn't know" if any treatment was given to this patient.

Treatment of Patients

- Clinic staff gave all women the same dosage of fentanyl without regard to body weight, so the clinic overdosed 17 of 18 patients on fentanyl for sedation.
- The staff failed to check vital signs for 18 out of 30 patients while they were in the recovery room. These patients had received fentanyl and/or valium but were left unmonitored.
- The facility failed to monitor the oxygen saturation of one patient under sedation.
- The clinic failed to monitor or record vital signs for women who were under sedation.
- Physical examinations weren't conducted before sedation and medical procedures and proper medical histories weren't taken. The clinic also failed to ask patients what other medications they were taking and what medications they were allergic to before giving sedation and didn't document this.
- The staff didn't document (or possibly conduct) Rh counseling for 5 out of 5 patients who were Rh-negative. Rh sensitization presents a risk to infants born in future pregnancies and can cause miscarriages of subsequent pregnancies.
- Clinic staff didn't document (or possibly give) patients proper counseling about aftercare after their procedures.
- There was no documentation or indication that the facility was giving patients proper informed consent before medical procedures.
- The facility failed to have a policy in place to inform doctors of adverse reactions and medication errors.
- Staff failed to verify whether patients who had experienced sedation had someone to drive them home.

Other

- The facility didn't ensure that contracted services were provided safely and effectively. This was also an ongoing problem, cited in multiple inspections, with 71 different contracted services involved. The clinic also failed to keep a list of contracted services, including their scope and nature. This included pharmacy services, lab services, trash disposal, fire alarm, and sprinkler maintenance, and phone services.

- Although there was a committee tasked with implementing proper infection control procedures, that committee failed to meet regularly. When they did meet, the person designated to oversee infection control wasn't present. The medical director also failed to attend some of the meetings.
- No fire or safety inspections were conducted at the clinic.
- The clinic failed to have a plan to conduct fire drills.
- The facility failed to keep a proper log of controlled medications, presenting the possibility that some could be stolen or misplaced. Controlled substances were also left unsecured, where unauthorized persons had access to them.
- The clinic administrator failed to attend 5 of 5 meetings of the clinic governing board.
- The state license wasn't posted where patients could see it.
- The clinic had medications that were not listed in the formulary.
- There were concerns reported with a contracted waste disposal company, but no record of corrections or resolution.

Indianapolis
(book excerpt)

No Choice: The Destruction of Roe v. Wade and the Fight to Protect a Fundamental American Right, by Becca Andrews (New York: Public Affairs, 2022)

Book Excerpt:

When [Ann] began the new job, she was taken aback by the bare-bones training given to her and the dim dustiness of the clinic. She had a hazy memory of shadowing another counselor before she officially started her job, along with informal conversations with the clinic administrator that covered some of the do's and don'ts of the work . . .

An administrative office in the back smelled of cigarettes; the staff would sometimes come in on Saturdays when the clinic was closed to clean it themselves, to save money on janitorial staff . . .

Ann: "It did not have the kind of feel you expect when you walk into a doctor's office. I felt a sense of kind of shame because you want to help these women during what, for some of them, was a really difficult moment. You just realize that the standard is really not high, and there's this defeatist attitude of *there's only so much you can do*."

Once, in a procedure room, she accidentally stepped on a blood clot, and no amount of sanitizing spray could make her feel like her shoe wasn't somehow forever tainted.

The carpets were stained; the clinic doctor liked to joke that it looked like a bloody body had been dragged down the hallway. He didn't seem to notice – or care – that his quip never got a laugh . . .

[A]nother clinic worker accidentally stuck herself with a used needle. The lab room she worked in was small, and the space limitation combined with the frenetic pace of the work meant that it was only a matter of time before there was an accident… [T]he worker wound up on medication meant to ward off the [AIDS] virus.

Lafayette

The health department document from 2019 can be found at:

www.problemsatplannedparenthood.org/indiana

Highlights:

Medical Records and Labels

- Doctors failed to sign medical records, and records were incomplete.

Merrillville

The health department documents from 2014, 2017, and 2019 can be found at:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- Potentially infectious material was stored in a cabinet, and the cabinet wasn't labeled as containing biohazardous material.
- The facility failed to document (and possibly perform) electrical leakage checks of equipment. This was for 5 of 5 pieces of equipment, including the autoclave, centrifuge, and exam lights.

Staff

- The medical director hired a doctor without verifying his credentials.
- The facility failed to ensure that staff was vaccinated and failed to provide Hepatitis B immunization to staff who requested it. Some of the staff were unvaccinated for diseases such as rubella, measles, and others.

Medical Records and Labels

- Doctors failed to sign paperwork. This was noted in two inspections. Physicians didn't sign to indicate that they took a proper medical history.
- The clinic failed to ensure that records were complete and accurate. This was cited in two inspections. One patient's records stated the patient was discharged at 8:55 AM, but had vital signs taken at 9:38 AM. Another chart indicated a patient was discharged at 2:05 PM but had vital signs taken at 3:06 PM. A third

patient was said to have gone to the recovery room at 12:59 PM but recorded as discharged at 12:11 PM. A fourth record documented a discharge time of 11:20 AM but claimed vital signs were taken at 12:56 PM and 1:02 PM. There were multiple other examples.
- Type of sedation patients received was not documented.
- Records failed to verify that patients understood discharge instructions.
- The facility had no policy to protect patient records from fire, water, or other damage.

Treatment of Patients

- According to the report, the facility "failed to ensure the implementation of policy and standards of care related to the checking of vital signs in the procedure and recovery rooms." There were no vital signs taken for 28 patients.
- The facility failed to conduct Rh counseling for Rh negative patients. Failure to treat Rh incompatibility can lead to miscarriage or health problems for the baby in future pregnancies.
- Patients weren't given proper instructions as to hygiene and self-care after their surgery. Paperwork given to patients omitted this information.

Other

- The governing body of the clinic failed to review and evaluate laundry and pharmacy services.
- There was no policy in place to report adverse reactions to medication or medication errors to the doctor.
- The facility didn't have a policy to deal with health care workers' practice problems. They had no policy for dealing with providers coming in under the influence, having criminal histories, needing disciplinary actions, or other potential problems.
- The clinic had no policy for infection control. The staff member in charge of infection control wasn't qualified for that position, and had not been trained.
- The facility didn't have a plan in place for working with state and federal agencies in the event of an emergency.

Kansas

Overland Park
(Kansas City metro area)

The health department document from 2015 and the pharmacy regulation document can be found at:

www.problemsatplannedparenthood.org/kansas

Health Department Document Highlights:

- None of the staff members had received a medical exam to clear them medically for working with patients.
- There was no record of immunizations for any of the workers. Nonvaccinated people can spread diseases to patients.

Excerpt from the Summary Order on Pharmacy Regulations:

1. The Board has previously issued Responded Registration No . . . which entitles Respondent to function as a pharmacy in the State of Kansas . . .
2. On or about July 2, 2015, the Board office received notification from Respondent of Pharmacist in Charge ("PIC") . . . Shafer's resignation effective August 20, 2015 . . .

12. Respondent failed to submit the complete Change of PIC application and new PIC exam to the Board until April 27, 2016, which was 179 days beyond the 30-day window for designating a new PIC.

ORDER

. . . Respondent is ordered to pay a fine . . . Because Respondent was 179 days late, the fine accrued . . . Respondent has 30 days from the date of this order to pay the full $4,580.00 . . .

Louisiana

New Orleans

The health department documents from can be found at:

www.problemsatplannedparenthood.org/louisiana

From 2018 document:

Description of Violations: Dust control methods are not being employed. RESTROOM AIR VENTS

From 2021 document:

Description of Violations: Dust control methods are not being employed. dusty tiles noted

Maryland

Annapolis

The health department document from 2013 can be found at:

www.problemsatplannedparenthood.org/ maryland-annapolis-baltimore

Highlights:

Clinic Conditions

- The autoclave, used to sterilize dirty instruments, wasn't properly sanitized or maintained. There was no documentation that basic maintenance was performed, and it was leaking onto shelves below.
- Routine spore testing (for mold) wasn't conducted on the autoclave.

Baltimore

The health department documents from 2013, 2015, and 2016 can be found at:

www.problemsatplannedparenthood.org/maryland-annapolis-baltimore

Highlights:

Staff

- A member of the nursing staff didn't appear to have experience or documentation of training to be competent in administering and monitoring intravenous sedation yet was administering sedation.
- Staff wasn't trained in the process for emergency transfer of a patient to the hospital in case of a complication. The manager acknowledged the staff member in question hadn't been trained.
- A member of the staff had no certification or training in CPR and basic life support.

Medical Records and Labels

- All five patient medical records examined were missing information. In all cases, the patients' discharge diagnosis had been omitted.

Other

- The staff failed to conduct fire drills. This remained the case in an inspection a year later.

Michigan

Ann Arbor

The health department documents from 2014 and 2017 can be found at:

www.problemsatplannedparenthood.org/michigan

Highlights:

- The facility mixed clean and dirty instruments, potentially causing contamination. Clean instruments were being wrapped in the same place dirty instruments were being processed.
- There was no emergency call system in the bathroom. A patient having a medical crisis couldn't press a button to inform a nurse or other staff.
- The facility failed to post its license where it could be seen by patients.
- Patients were allowed to bring personal items into the operating room, without proper containment.

Flint

The health department documents from 2015 and 2016 can be found at:

www.problemsatplannedparenthood.org/michigan

Highlights:

- Privacy curtains prevented nurses from seeing patients in the recovery room. The curtains obstructed their view and they couldn't see if patients were in distress.
- Patients were allowed to bring personal items into the operating room, without proper containment.
- Single dose medications were used on multiple patients.

Missouri

Colombia

The health department document from 2018 can be found at:

www.problemsatplannedparenthood.org/missouri

Highlights:

Clinic Conditions

- Suction machine cabinets were rusted and covered with adhesive tape, creating an uncleanable surface that could harbor infection-causing germs. One suction machine cabinet also had a six-inch-long dried brown stain on it. This was likely bodily fluids or blood that hadn't been cleaned.
- Tubing attached to the suction machine, intended to be used only once, wasn't disposed of between patients. The tubing was contaminated with red "bodily fluids." The bloody tubing was still there six days after the last surgery.
- Re-usable tubing was contaminated with "a blackish-gray substance," determined to be mold. Staff admitted mold had been present in the tube for four months, though using it on women.
- The re-usable glass bottle attached to the suction machine had a layer of "dried black substance" congealed on the bottom, likely dried blood and fluids.
- Exam tables were wooden with chipped paint, presenting an surface that couldn't be disinfected.
- A cabinet under the sink hadn't been cleaned and had a "large area of dried white residue and an area of dried yellowish-brown residue."
- Equipment used on patients wasn't approved for use in healthcare facilities. Heating pads were labeled "for household use only." One of the heating pad covers was stained.
- The facility improperly used heating pads on patients who were sedated or had been given pain medication, which could lead to burns.

St. Louis

The health department documents from 2009, 2013, 2015, 2016, and 2019 can be found at:

www.problemsatplannedparenthood.org/missouri

Highlights:

Clinic Conditions

- The facility used worn, rusted, and deteriorating equipment with uncleanable surfaces, including a rusted surgical table. A stool for patients was covered with rust and clear tape, creating an uncleanable surface.
- An air vent was clogged with dust and debris.
- Plastic bins containing emergency supplies, IV solution, and IV supplies were covered in dust.
- An IV pole was rusted and in poor condition.
- An oxygen tank was dirty and covered with adhesive surfaces.
- The facility failed to keep the procedure rooms, supply rooms, and storage rooms free of dust and debris. The floor had visible dust and dirt. This was noted in multiple inspections.
- An exam tabletop pad was torn, with exposed foam, creating an uncleanable surface. The clinic hadn't ordered a replacement.
- There was a dirty cloth pillow on the ultrasound table. The pillow was white but part of it was discolored gray.
- Pillows on tables in the procedure rooms had unzipped or missing plastic covers and were therefore uncleanable.
- The refrigerator was dirty and had tape and adhesive residue on the front, creating an uncleanable surface. There was hair and dust inside the refrigerator. A staff member was questioned and said he hadn't cleaned the refrigerator or seen it cleaned in the 1 ½ years he worked at the clinic.
- The cabinet where IV catheters were stored had a thick layer of dust on the shelves.
- There was tape, adhesive residue, and peeling labels on cabinets and clipboards, creating uncleanable surfaces.
- Drawers contained dust, debris, and adhesive residue.
- Instruments were stored in a drawer that was dirty with dust and debris.
- There was a brownish residue on the floor and inside a cabinet. This may have been dried blood and/or bodily fluids.
- An ultrasound had tape on it and was extremely dusty, as was the case with a plastic tray holding protective bed pads. A wheelchair regularly used for patients also had a thick layer of dust.

- In a subsequent inspection, oxygen masks, nasal cannulas, and sterile IV tubing were found stored in bins that had “dust and loose particles” in them.
- There was expired medication, including IV fluid and ammonia (used to treat fainting), which had expired three years before. Nine vials of valium, being used on patients, had been expired for nearly a year. Other expired medications included naloxone (which is needed to give life-saving treatment to patients suffering from a narcotics overdose) and dextrose injectables. In another inspection, an expired epi-pen was found.
- Having and using expired medication was a repeat offense, cited in multiple inspections.
- The facility had expired postpartum balloons (used to stop bleeding) including one that had expired three years before. There were surgical gloves that expired six years before. In another inspection, inspectors found hand sanitizer expired by a year and expired thermometers.
- Glucose testing strips were supposed to be disposed of six months after opening. After that, they could give inaccurate results. Staff failed to note the date when the testing strips were opened, and one staff member in the lab said he had “no idea” when they were opened.
- The facility failed to inspect and maintain fire extinguishers.
- The facility failed to monitor the humidity in instrument processing areas.
- The facility failed to protect sterile items from dust and moisture by placing a solid barrier beneath them when they were on shelves.
- Staff didn’t have the manufacturer’s operating instructions for the autoclave, used to sterilize instruments. Instructions were eventually printed out from the internet. These instructions gave detailed information on how to clean and replace parts in the autoclaves. There were no records to show that the autoclave was properly cleaned and maintained. The insides of the autoclaves were discolored and had brown spots. These autoclaves were being used to sterilize instruments.
- In the sterilization room, around one of the autoclaves, there were dust and white flecks which left a mark when a finger was pulled through it.
- Staff failed to follow the manufacturer’s instructions to test the autoclaves, which are to be done after each instrument load. The tests were performed only once a week.
- The clinic failed to have a procedure in place to prevent cross-contamination of clean instruments by dirty ones.
- Instruments weren’t properly sterilized.
- Peel packs were covered in off-white flakes that fell off when they were lifted. When clinic staff was asked about this a staff member admitted she didn’t know where the white flakes came from.
- Staff failed to store refrigerated medication at appropriate temperatures. RhoGAM, used to treat RH sensitization, had a required temperature range to remain usable. Frequently, ranges of temperature weren’t tested, but tests showed temperatures out of range for over a week. This wasn’t addressed. RhoGAM was allowed to remain at inappropriate temperatures for an extended period.

- Open medications were left in the procedure room and not kept in a centralized location.
- Unsterile corrugated boxes were in the sterile supply room.

Staff

- Two surgical assistants (out of four) weren't trained to assist in surgery, nor did they have certified surgical technologist credentials.
- The facility failed to perform Employee Disqualification List (EDL) checks on any of its employees before hiring them. Medical facilities are forbidden to hire staff whose names appear on the EDL.
- The facility failed to run criminal background checks before hiring. They also failed to perform background checks on volunteers, including one volunteer who had been there for over 30 years. This was an ongoing problem, cited in more than one inspection report.
- The staff didn't wear appropriate personal protective equipment. Inspectors observed one staff member cleaning instruments without wearing a mask or face shield.
- The facility failed to provide ongoing training for staff in infection control. One staff member had been working at the clinic for nearly 10 years and had no infection control training.
- The facility didn't conduct proper orientation for staff.

Medical Records and Labels

- The clinic failed to document medication given to patients. Names of medications, times they were given, and dosages were omitted from records. Some records were inaccurate – one patient's chart said that she received medication at 4:46 PM but was discharged at 12:55 PM.
- The facility failed to ensure medication orders were timed, dated, and signed by a physician.
- The staff didn't document ongoing issues with quality control.

Incidents

- The Missouri Department of Health investigated the clinic for complications in five cases, and all five doctors involved refused to cooperate. A letter from the Department states "RHS's non-cooperation on this point is unprecedented and untenable."

Treatment of Patients

- Single-use medications weren't discarded after one use, but were used on multiple patients. Clinic staff admitted that fentanyl vials were used on multiple patients because of a "shortage." Using single-use medication on multiple patients was cited in multiple inspections.

- The facility didn't give accurate information to patients concerning who to contact to file a complaint against the clinic or the process for doing so.
- The facility failed to monitor patients' vital signs, including those of patients under sedation. The facility failed to monitor level of consciousness, blood pressure, pulse, oxygen saturation level, and respiratory rate frequently enough throughout the time patients were under sedation. This put patients at risk.
- Residents performing surgery weren't properly supervised.

Other

- Staff wasn't knowledgeable about evacuation plans in the event of a fire, and fire drills weren't conducted.
- The facility didn't submit pathology specimen reports to the Missouri Department of Health and Senior Services, as they were required to do.

North Carolina

Chapel Hill

The health department documents from 2014, 2015, 2016, and 2017 can be found at:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Staff failed to clean and disinfect the floor in the procedure room. Inspectors found dirt and rust on the floor. There were dirt stains on the floor at the foot and head of the exam table. The floor wasn't cleaned between patients or even daily, but only several times a week, by janitorial staff

Staff

- Medications were administered by unlicensed, unqualified staff members. This included intramuscular injections of RhoGAM and birth control injections.

Medical Records and Labels

- The facility failed to document medication administration properly in its records. They didn't record at what times medications were given. Multiple inspections documenting this.

Treatment of Patients

- The facility failed to conduct proper informed consent, as cited in multiple inspections.
- In seven out of seven cases, the facility failed to give women instructions about what to do and who to contact in the event of medical emergencies.
- Staff failed to sterilize a vaginal ultrasound probe between uses. They used the ultrasound probe on multiple women without properly cleaning and disinfecting it. This has the potential to spread infections.

Fayetteville

The health department documents from 2015 and 2016, can be found at:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- The facility had expired medications and supplies. An oxygen mask required for emergencies had expired eight years before. Needles and curettes were expired by over two years, and other supplies were also expired.

Treatment of Patients

- The facility was required to keep women in the recovery room for at least an hour after surgery to make sure there were no complications. Staff failed to do this. Women were discharged 35 – 37 minutes after surgery and were not observed long enough to rule out complications.

Wilmington

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Blood samples and human tissue were stored in the same refrigerator as medications. This brings a risk of cross-contamination.

Medical Records and Label

- Doctors failed to sign consent forms.

Winston-Salem

The health department documents from 2015 and 2016 can be found at:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Biohazardous waste, including used needles, was stored close to employees' personal belongings and extra supplies.
- A syringe filled with lidocaine was left unattended and unsecured, leaving open the possibility of contamination or tampering.
- A disposable lab coat and masks were used repeatedly, and there was not enough personal protective equipment for the staff.

Staff

- There was no evaluation of competency for staff preparing and administering medication. One of the doctors administering medication was not registered with the North Carolina Board of Pharmacy. The clinic failed to ensure that a healthcare assistant preparing medication was competent to do so.
- The staff didn't properly disinfect instruments. The staff failed to "follow safe practices to prevent the spread of infection," according to the report. There was possible cross-contamination between dirty and clean instruments as dirty instruments were lifted and passed over clean ones. Staff kept dirty and clean instruments in the same sink.
- Staff failed to wear sufficient personal protective equipment when handling dirty instruments.
- According to the clinic's regional director, "a lot of our docs don't use masks during procedures."

Medical Records and Labels

- Documents verifying informed consent weren't signed by doctors. This was the case for every patient whose paperwork was examined. This was an ongoing problem, also cited in a second inspection two years later.
- In this second inspection, it was also found that the time of the procedure wasn't given for any of the patients whose records were examined. By way of excuse, the clinic's regional director said that the clinic's health service manager "did not receive the proper training and it was just poor training on my part."

Other

- The facility failed to conduct periodic checks of emergency equipment including the emergency defibrillator. The clinic's regional director and vice president said, "I know we aren't checking it, and to be honest, we haven't looked at the manufacturer recommendations or developed a protocol. We are going to have to determine how often checks should be done . . . Maybe every six months or maybe we need to do it every month." This lack of testing of equipment needed in an emergency could put patients' lives at risk.

Ohio

Bedford Heights

The health department documents from 2013, 2014, 2015, 2016, and 2019, along with a letter assessing a fine, can be found at:

www.problemsatplannedparenthood.org/ohio

Highlights:

Clinic Conditions

- According to an inspection report, the facility "failed to ensure a safe and sanitary environment" for patients, visitors, and staff.
- Walls in the waiting room were darkened, dirty, and discolored. A review of the contracted cleaning staff's duties revealed that the walls weren't cleaned.
- The clinic failed to ensure appropriate ventilation and humidity levels in the operating rooms and recover rooms, increasing the risk of infection to patients.
- The facility had expired supplies, including test strips to determine whether the proper concentration of disinfectant was used to sterilize instruments. This was a repeat offense. In a later inspection, the facility had and was using expired products for skin dressings, hand hygiene, and disinfectant.
- The waiting room door's automatic release wasn't working, possibly preventing patients and staff from exiting the building in the event of a fire or other emergency.
- Fire extinguishers, which were supposed to be inspected monthly, had not been inspected for several years.
- Several tests had labels indicating they should only be used within three months after opening, but products were opened and undated.
- Saline, only good for 60 days after opening, had been opened two years ago and was being used.
- Cardboard boxes were stored in an unsafe manner, creating a fire hazard.

- Band-Aids had been removed from the manufacturer's protective packaging. Staff claimed that the Band-Aids were open and exposed to save time.
- Condoms were used to cover the ultrasound probe which was placed inside women. These condoms were stored unwrapped before use, an unsanitary situation.
- A full urine specimen cup was left sitting in the bathroom for four days, untested and not disposed of.
- The facility wasn't monitoring temperature in the refrigerator where fetal remains were kept. Too low temperatures could allow decomposition and create a health risk. The refrigerator also wasn't given proper maintenance and testing.
- The facility failed to post the complaint hotline where patients could see it.
- There were unlabeled filled syringes with no indication of what medication was in them. A staff member admitted, "we don't know what's in them."

Staff

- None of the nurses on staff had surgical experience and none was qualified to be the director of nursing.
- Doctors didn't have proper privileges to perform surgery, and there was no documentation of competence from the governing body of the clinic. The facility did not conduct evaluations based on medical records and references on their doctors. According to the inspection report, "this could affect all patients receiving surgical services in the facility."
- The facility failed to conduct tuberculosis testing on newly hired staff.
- The facility failed to perform a yearly evaluation of staff.

Medical Records and Labels

- Medical records for patients were incomplete and missing information in all the records inspectors looked at. Vital signs were not recorded and may not have been taken. This was a repeat offense, with another inspection also finding omissions in patient records.
- Records weren't signed, and the times medications were given weren't recorded.
- There were also mistakes. One claimed the patient was given pain medication 1.5 hourse after she was said to have left the facility.

Incidents

- A surgery patient suffered hemorrhaging and was taken by ambulance to the hospital. The clinic didn't send her medical records to the hospital or notify the hospital's emergency department.
- A second patient was also transferred to the ER having suffered a uterine perforation, which is potentially life-threatening. She needed laparoscopic surgery.

- The facility didn't have "legible and complete" records on either of these women, omitting various pieces of information including medical outcomes. The writing in the records was illegible and couldn't be deciphered by staff or inspectors.

Other

- The facility allowed unauthorized persons to have access to controlled substances. The facility also failed to properly repackage narcotic painkillers.

Cincinnati

The health department documents from 2012, 2013, 2014, 2015, and 2016 can be found at:

www.problemsatplannedparenthood.org/ohio

Highlights:

Incidents

- A minor patient having surgery suffered an allergic reaction and an asthma attack and had to be taken to the hospital.
- Fifteen patients suffered incomplete procedures. Another three women hemorrhaged, and one needed a blood transfusion.

Treatment of Patients

- The facility failed to have a transfer agreement with the local hospital, putting patients at risk in the event of complications from surgery.

Columbus (East)

The health department documents from 2012, 2013, 2015, and 2018 can be found at:

www.problemsatplannedparenthood.org/ohio

Highlights:

Clinic Conditions

- A suction machine and its table, still in use, were coated with a heavy layer of dust and dirt.
- Patient care supplies were stored in an unsanitary manner, cardboard boxes directly on the concrete floor.

- One exam table had a large tear in its vinyl cover, exposing foam and making it impossible be sterilized. A staff member said the tear was brought to the attention of clinic administration a month before, but had not been repaired.

Medical Records and Labels

- The facility didn't properly label filled syringes and open vials of medication. Filled syringes didn't have the dosages on them, which led one staff member to say he would be afraid to administer the medication to patients. Open vials of medication weren't all labeled with the date they were opened.
- The facility failed to document the times medications were given to patients.

Treatment of Patients

- The facility was only supposed to discharge patients who were accompanied by someone. The facility sent patients away alone, and without documentation they were well enough.
- The facility failed to post the complaint hotline where patients could see it.

Other

- Controlled substances weren't in a double-locked storage area, so they could be accessed by unauthorized persons.

Pennsylvania

Allentown

The health department documents from 2012, 2014, 2017, and 2018 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- There were expired medications in the emergency kit.

Staff

- The facility failed to perform criminal background checks on some of its employees.

Medical Records and Labels

- Boxes of patient records were stored under water-stained ceiling tiles. The boxes weren't stored in a manner that prevented water damage.

Privacy

- The facility failed to keep medical records with patient information private. Medical records were stored in a manner where patients' names were visible.

Incidents

- A woman's uterus was perforated during surgery and she was transferred to a hospital. The facility failed to notify the woman of her complication in writing, as required.
- A second woman hemorrhaged after surgery, suffering from "excessive bleeding with noticeable large clots." Staff called 911 and she was taken to the hospital by ambulance. The facility didn't conduct an internal investigation into the incident and failed to report the complication to the Department of Patient Safety Authority as required. The facility also failed to evaluate and discuss the case at its Patient Safety Committee Meeting and made no recommendations to prevent such events in the future.

Treatment of Patients

- The facility failed to ensure that there was a licensed nurse on duty in the recovery room. Patients were therefore not properly monitored for complications after surgery.
- The facility failed to ensure only nonflammable agents were used for pre-surgical preparations. The facility was using an improper surgical prep (chlorhexidine gluconate solution 4.0%) to prepare patients' cervixes for surgery.
- The facility failed to administer RhoGAM shots to every patient who was Rh-negative. Without a RhoGAM shot, an Rh-negative patient can develop Rh sensitization after surgery. Rh sensitization can lead to stillbirth, infant death, or medical complications for the infant and mother in a later pregnancy.

Harrisburg

The health department documents from 2012, 2017, and 2018 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- One of the patient restrooms was found to be dirty.
- One of the exam tables was ripped, and the tear was held together with duct tape.
-

Staff

- An employee had long fingernails with acrylic nail polish, which inspectors felt created an unsanitary situation.
- The facility failed to conduct performance reviews for four out of five employees.

Medical Records and Labels

- The facility didn't keep copies of reports that were submitted to the Health Department.

Norristown

The health department document from 2012 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- the facility "failed to provide a functional and sanitary environment for the provision of surgical services" and didn't "adhere to professionally acceptable standards of practice for the sterilization and disinfection of equipment."
- Machines for sterilizing equipment were only given spore tests (mold tests) monthly when manufacturer's instructions require weekly tests.
- Surgical instruments were covered with rust. This included suture scissors, speculums, and other instruments. These instruments were being used on patients.
- There was no emergency call system in the operating room or the recovery room. There was no intercom in the exam room.

- The facility had no cardiac monitors or defibrillators. The facility also didn't have any tracheostomy supplies, which might be needed in an emergency.
- The facility failed to ensure that there was a "properly conditioned air supply in critical areas of the facility."
- The facility failed to monitor the temperature and humidity in operating rooms or the recovery room.
- There was no nurse's station in direct view of the recovery room.
- There were no cubicle curtains for patient privacy in the recovery room.
- There was no scrub station located near the operating room.
- The facility's Soiled Storage Room, where biohazardous waste was stored, was a small closet. The facility had no provision for disposing of fluid waste.
- There was no area where staff could change their clothes or put on scrubs.
- Dirty instruments, linens, and other items are supposed to be kept separate from clean ones and kept in different areas. Instead, sinks and counters were used for both dirty and clean items. Wrapped sterile supplies were stored in the same area as dirty items. Syringes and needles were also stored close to dirty items.
- There were no temperature, humidity, or ventilation monitors where sterile supplies were stored.
- Medical waste wasn't kept in a designated area but scattered throughout the facility.
- Bathrooms were not equipped with hardware that allowed staff to enter them if a patient was having a medical emergency.
- There were no grab bars in the bathrooms. Therefore, they were not handicapped accessible.
- Doorways, including entrances and exits from the facility, were too narrow to accommodate a gurney in case of an emergency.
- The facility had no oxygen or vacuum available for emergencies.
- Clean and sterile items were kept in the same area as blood and urine samples.
- The facility had no room dedicated to laboratory tests.
- Staff used dirty, unsterilized brushes to clean instruments.
- Bottles of Tylenol with codeine, which were a controlled substance, weren't stored in a double-locked cabinet and were therefore accessible to unauthorized persons.

<u>Staff</u>

- There were no employees trained in Pediatric Advanced Life Support (PALS) for surgical procedures performed on children under 18 years of age. None of the doctors, nurses, or other employees were trained to conduct CPR on minors. Yet the facility had performed surgery on 77 minors in the past 11 months.
- facility didn't have processes in place to perform criminal background checks on employees before hiring. They were not conducting background checks.
- The facility failed to conduct annual performance evaluations on half of its employees.

- None of the facility's doctors were licensed to administer anesthesia, but they were administering anesthesia anyway.

Treatment of Patients

- The facility didn't have a contract or agreement with an ambulance service, putting patients in danger in case of emergencies.
- Staff failed to monitor patients' oxygen saturation while they were under anesthesia. The facility had no equipment capable of monitoring oxygen saturation. This created a risk for patients.
- The facility was giving expired medications to patients.

Philadelphia (Locust Street)

The health department documents from 2013, 2015, 2016, 2017, and 2018 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- According to the inspection report "the facility failed to provide a safe and sanitary environment."
- The cushion of a bench patients were expected to sit on was covered with multiple dark stains – likely blood or bodily fluids.
- The area where drugs, including narcotics, were stored wasn't periodically checked by a pharmacist or practitioner, and no log was kept.
- The facility failed to maintain temperatures per established guidelines in the Recovery Area. It was too cold.
- 20 Gauze Sponge packets used in surgery were stored under a sink in the procedure room.
- The facility's lab refrigerator/freezer, for storing control tests, had a buildup of ice.
- All of the wraps and pouches of sterilized instruments had wet stains on them.
- A metal container in the sterile processing room wasn't properly sterilized.
- There were multiple darkened stained areas on the carpeted floor in the recovery room.
- The facility had no policy on how long to soak instruments in sterilizing solution as per the manufacturer's instructions. This could lead to instruments being used on women that weren't properly sterilized.
- The facility failed to properly store human tissue, creating unsanitary conditions. Biohazardous waste was stored in an unlocked refrigerator in an unlocked closet. Biohazard bags were undated.

- The facility was cited for numerous health code violations, and the facility's administration submitted a plan of correction. When the inspectors came back the next year, this plan hadn't been implemented. According to the report: "the facility failed to correct deficient practice and failed to follow the Plan of Correction submitted to, and accepted by, the Department of a full State Licensure survey… for one of six deficiencies cited."

Treatment of Patients

- The facility wasn't reporting statutory rape or sexual assault of minors. They had no policy in place to do so.
- In 6 of 6 cases of pregnant minors under 16, the facility failed to ascertain whether the girls were victims of abuse by an adult and failed to report the incidents. These were four 13-year-olds and two 14-year-olds who were pregnant. No questions were asked, and no reports were made. Two of the minors reported that their first sexual intercourse occurred when they were twelve or younger. This wasn't reported.
- The facility failed to do physical examinations and assess patients' physical status before administering anesthesia and doing surgery.
- The facility failed to have a doctor supervise the nurse who gave anesthesia, nor were any doctors certified to give this supervision. The nurse giving anesthesia was not registered with the National Practitioner Data Bank.

Staff

- The facility failed to request and consider reports from the National Practitioner Data Bank for employees, which is a tool to prevent medical professionals from moving from state to state without disclosing previous medical malpractice.

Incidents

- A patient suffered a "serious event," i.e., a complication, and the facility failed to notify her in writing of the complication within seven days, as required.

Other

- When the entity that owns the facility (Planned Parenthood Southeastern Pennsylvania) held a Risk and Quality Management meeting for all its affiliates, no one from the facility attended.

Philadelphia (Far Northeast)

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

- Potentially infectious pathological waste was improperly stored.
- The facility had no freezer or refrigerator for storing human tissue, so they stored it at room temperature.
- Staff didn't use preservatives, but simply boxed the tissue to be picked up by a waste disposal company. This presented a health hazard due to potentially decomposing human tissue.

Pittsburgh

The health department documents from 2013 and 2016 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- According to the inspection report, "the facility failed to keep the premises and equipment clean."
- There were multiple large stains on the carpet on the floor of the patient waiting room.
- In the ultrasound room, there was heavy dust on the sharps container, paper towel dispenser, and picture frames.
- In the operating rooms, there was excessive dust on picture frames, paper towel dispensers, cabinet tops, and door frames.
- In the dirty utility room, there was a buildup of dried sanitizing material adhering to the bottom and sides of the wash station. This was where instruments were cleaned.
- The facility failed to maintain medications within the recommended temperature ranges noted on the manufacturer packaging for four out of four medications.

Staff

- The facility failed to document background checks on employees, as was required.

Warminster

The health department documents from 2012, 2016, 2017, and 2018 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Clinic Conditions

- The facility improperly stored sterile surgical supplies and kept them in an unsanitary manner. There were no temperature, humidity, or ventilation monitors observed in this area where sterile wrapped packages were stored.
- The facility failed to store clean scrubs to minimize contamination from surface contact.
- Soiled and dirty linens were stored with clean ones.
- Soiled linens weren't washed at a high enough temperature to kill microbes and prevent infections.
- There were no policies to conduct routine preventative maintenance on equipment.
- The facility failed to monitor temperature and humidity in its operating rooms or the recovery room.
- There were no call bells or intercom systems in the operating room or in patient bathrooms, interfering with summoning help in an emergency. A bathroom door also opened inward, possibly preventing access in an emergency.
- There were no cubicle curtains for privacy in the recovery room.
- The soiled work area and the clean work area weren't physically separated.
- There were no scrub sinks located outside of the operating rooms. The sinks inside the procedure rooms were not hands-free.
- The facility failed to ensure all required emergency equipment was available in two of the procedure rooms for resuscitation measures when surgery was performed. Emergency supplies were missing from the crash cart.

Staff

- The facility failed to conduct background checks on its employees.
- The facility failed to have a Director of Nursing who was responsible and accountable to the person in charge of the facility.
- Half of the employees weren't trained in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if the electric power was impaired.
- Two of the staff did not have hepatitis B vaccines. The facility was required to offer the shot to any worker who had contact with blood or bodily fluids. There was no indication that the shots were offered, but both the staff members had requested them.

Medical Records and Labels

- The facility failed to ensure the post-operative surgical reports were written or dictated immediately after the procedure by the operating practitioner for 20 of 20 medical records reviewed.
- The facility didn't have discharge summaries for patients in any of the medical records examined by inspectors.

Incidents

- Staff at the facility perforated a woman's uterus and failed to report the injury to the Board of Health. They also failed to notify the woman of the complication in writing. The inspection report defined the perforated uterus as a "serious event," meaning "an event, occurrence or situation involving the clinical care of a client [that] … compromises client safety and results in an unanticipated injury requiring the delivery of additional health services to the client." The patient suffered "minimal pelvic hemorrhage" and needed further medical care.

Treatment of Patients

- The facility had untrained, unlicensed staff monitoring women in the recovery room after their surgery. They were monitoring patients' blood pressure but weren't qualified or trained to do so.
- In all cases, the staff failed to inform women that they might need to visit a hospital in the event of an emergency.
- The only guidance on dosages of drugs to give in an emergency was for adult patients. This meant that a minor having a medical emergency might not receive the right dose of emergency medications.
- The facility failed to do a proper physical evaluation on any of its patients before doing surgery and/or administering anesthesia on them.
- The facility was using expired medications and had no policy to dispose of them.
- The facility failed to ensure the maximum recommended dose of Lidocaine (an anesthetic) was not exceeded when administered as a paracervical block in 8 out of 10 cases. The facility always gave the same dose of lidocaine, despite the patient's weight and/or medical condition.

Other

- The clinic's policy concerning minors "did not meet the criteria of the Child Protective Services Law."
- The facility had no policies in place for the evacuation of patients or patient records in case of a fire or other emergency.

West Chester

The health department documents from 2011, 2012, 2014, and 2017 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- A foul odor was noted and was present throughout the facility.
- The suction machines used in surgery didn't have a preventive maintenance label to indicate the inspection date. There was no indication they'd been inspected.
- Medical supplies were expired, including a box of masks that had been expired for five years and two packages of gowns that had been expired for four.
- Human tissue from surgery was stored in a paper bag that was leaking blood in the refrigerator.
- The facility failed to ensure that linen was handled in a manner to minimize contamination. Linens weren't washed long enough, and the clinic staff didn't monitor the temperature of water to determine if it was hot enough to properly sterilize the linens.
- The facility failed to inspect and properly maintain the ventilation system.
- The facility failed to monitor the temperature and humidity levels in the operating rooms and post-anesthesia care area.
- Automatic fire extinguishing systems and fire alarms weren't inspected and tested.
- Grab bars were missing in the patient bathroom, meaning it was not handicapped accessible.
- There were no cubicle curtains for privacy in the recovery room.
- The soiled work area and clean work area were located together in the same room, raising the risk of cross-contamination.
- The facility didn't meet structural requirements – the floor didn't have sealed seams and the operating rooms were too small.
- There were no hands-free scrub sinks located outside the operating rooms.
- The facility failed to ensure controlled substances were properly secured. For example, 26 containers of Tylenol with Codeine were left in an open cardboard container on the countertop in the recovery room.
- According to an inspection report, "the facility failed to adhere to professionally acceptable standards of practice to assure a functional and sanitary environment."

Staff

- One of the doctors who maintained a supply of controlled substances, dispensed, and prescribed controlled substances didn't have the proper certification from the DEA.
- The facility failed to conduct background checks on its employees and didn't have a policy for doing so.
- There was no documentation that a doctor had privileges to administer anesthesia. There was no delineation of privileges regarding doctors administering anesthesia.

Medical Records and Labels

- The facility failed to have a written policy regarding the retention of medical records. It also failed to have a policy specifying which employees had access to medical records and under what conditions they could be released.
- There was no plan to evacuate medical records in case of an emergency.

Treatment of Patients

- The facility had a policy in place to monitor patients' blood pressure after surgery by taking vital signs every 15 minutes. However, this wasn't done for 11 out of 25 patients.
- The facility failed to provide a written policy for the discharge of an incompetent patient, i.e., a patient who couldn't consent to medical care because of age or mental condition.

Other

- Managers had erroneously instructed employees that they could turn away health inspectors if the inspectors arrived on a day that surgeries were being done.

York

The health department documents from 2012, 2013, and 2018 can be found at:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- The facility had no emergency call system in the bathrooms, operating rooms, and recovery area.

- The facility failed to ensure the ventilation system was inspected and maintained. They therefore failed to ensure that air quality was kept at proper filtration, humidity, and temperature requirements in operating rooms and the recovery room.
- The facility had no fire extinguishing systems or fire alarms.
- Ceilings consisted of textured tiles that were not scrubbable or gasketed.
- There were no scrub sinks located outside of the procedure rooms.
- Doors in the facility were too narrow to admit a gurney in case a patient needed to be transferred to the hospital in an emergency.
- The facility failed to have emergency equipment readily available for resuscitation purposes for procedures using local anesthesia.
- The only oxygen tanks in the facility were empty.

Staff

- The facility failed to request and consider reports from the National Practitioner Data Bank for both of its doctors. The facility credentialed doctors without examining and taking into account these reports. The National Practitioner Data Bank is a tool that prevents medical professionals from moving from state to state without disclosure or discovery of previous medical malpractice.
- The facility failed to ensure that a Registered Nurse was a member of the Quality Assurance and Improvement Committee. There was no RN on the committee, as required.
- Staff didn't have training or education in infection control

Medical Records and Labels

- None of the medical records contained documentation that the patients were assessed for nausea and vomiting before discharge.
- No post-operative surgical reports were written for six out of six patients.
- Entries in medical records weren't dated and authenticated by the person making the entries. Paperwork wasn't signed or dated in 100% of cases.
- The facility didn't have a policy regarding the preservation of medical records.

Incidents

- The facility failed to administer a RhoGAM shot to a woman who was Rh-Negative. This could lead to Rh sensitization, which can cause serious complications and infant death or disability in future pregnancies.
- A patient suffered medical complication, and the facility failed to notify the patient in writing of the event within seven days because, at the time, they had no patient safety officer.

Treatment of Patients

- The facility failed to ensure practitioners documented informed consent.
- The facility failed to conduct a physical exam and evaluation before performing surgery or giving anesthesia for six of six patients whose records were examined.
- The facility failed to ensure patients were properly identified by the operating surgeon before the start of surgery for six of six medical records reviewed. In every case, the surgeon didn't identify the patient prior to the start of the procedure.

Other

- The facility failed to ensure that a committee was established for the prevention, control, and investigation of infection.
- The facility didn't have written policies and procedures that only authorized persons in the proper attire could be in the surgical area.
- The facility failed to establish a workable plan with the nearest fire department.
- The facility failed to conduct fire drills.

South Carolina

Columbia

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/south-carolina

Modern Healthcare
Associated Press, September 12, 2015

Excerpt:

The Department of Health and Environmental Control issued suspension orders for Planned Parenthood's Columbia clinic and the Greenville Women's Clinic, citing violations found during recent inspections . . . The Columbia clinic was cited for 21 violations . . . Planned Parenthood's additional citations include having expired medicine and storing sterile and nonsterile gloves together.

South Dakota

Sioux Falls

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/south-dakota

Highlights:

Clinic Conditions

- Staff failed to test the steam sterilizer used to sterilize instruments to ensure there was no fungal growth or bacteria present inside it.

Tennessee

Memphis

The health department documents from 2015, 2016, and 2018, can be found at:

www.problemsatplannedparenthood.org/tennessee

Highlights:

Clinic Conditions

- According to the inspection reports, the facility failed to maintain an environment "in such a manner that the safety and well-being of the patients are assured."
- There were holes in three of the four walls in the elevator equipment room. There were four holes in the ceiling of the generator room. There were eight holes in the ceiling of the second floor mechanical room. There were holes in the walls in the boiler room. These problems were cited in multiple inspections, and were not fixed.
- The exhaust fan in the soiled storage room wasn't functioning.

The facility had the following fire hazards:

- A hand sanitizer dispenser was installed above a light switch.
- Electrical receptacles in a corridor had a damaged cover.

- Light fixtures in many of the rooms did not have bulb protection.
- The facility had not had its fire dampers inspected in four years.
- Access to a fire extinguisher was obstructed by an advertisement sign.
- Another fire extinguisher was taped to the wall and wasn't available to be used in an emergency.
- None of the fire extinguishers were being inspected or tested.
- Doors were blocked with rubber wedges, possibly preventing patients and staff from escaping in the event of a fire.
- Signs were stored in the hallways, interfering with evacuation in case of an emergency.
- In a different inspection, cases of water were blocking hallways and bottles of beer were blocking stairs leading out.
- There were unsecured oxygen cylinders in the surgery room.
- There were no hazard signs located in areas where oxygen and other flammable gases were stored.

This problem was not corrected and was cited in two different inspections.

Texas

Austin (South)

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/texas

Highlights:

Clinic Conditions

- The facility "failed to ensure a safe and s anitary environment for all surgical patients."
- There were pieces of debris around patient beds in the operating rooms. There were used alcohol pads on the floor of one OR and on the table in another. Staff said that the rooms had been cleaned and were ready for patients. They said they believed that the rooms had been cleaned the day before.
- The bed rests on tables in both OR's were covered with socks, and the socks weren't changed between patients.
- There was tape on multiple surfaces in both operating rooms. Tape creates a sticky surface that can't be properly disinfected.
- There was a "thick, visible layer of dust" on surfaces in both operating rooms. Inspectors said this indicated "ineffective cleaning."

- The facility was improperly sterilizing instruments. Sterile instruments were left open or sealed in a way that inspectors felt would prevent them from being fully sterilized.
- Packages of patient tubing and curettes were stored improperly, in potentially unsanitary conditions.
- Multi-dose vials of Lidocaine were stored improperly.
- Patient care items weren't taken out of shipping containers, and were stored within them, leading to possible unsanitary conditions. The publication "Preventing Infection in Ambulatory Care" states that shipping containers can be contaminated with dirt or other debris and shouldn't be stored with patient supplies to prevent contamination.
- * Two autoclaves (used to sterilize instruments) were also stored in the supply room with the shipping containers, leading to the risk of cross-contamination.

Treatment of Patients

- The facility was only supposed to discharge patients if they were accompanied by a responsible adult. The facility didn't follow this policy and sent patients away alone. There was no documentation that these patients were well enough to leave the facility and travel home alone.

Dallas (South)

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/texas-dallas-ft-worth

Highlights:

Clinic Conditions

- The facility "failed to ensure a safe and sanitary environment for surgical patients."
- A cabinet beneath the sink in the waiting room had a large circle of dark brown dried substance on it.
- The emergency call button in one of the patient bathrooms was too high off the floor for a patient to reach if they had fallen. A patient who had fallen to the floor would be unable to summon help in an emergency.
- Patient bags were stored on the sitting bench in the bathroom across from the toilet.
- Other patient bags and belongings were stored in a cardboard shipping box on the floor of the pre-op storage area.
- In another one of the patient bathrooms, three of the ceiling tiles had large brown water stains.

- There was no gauge on the oxygen tank that was available for patient emergencies. This meant the oxygen couldn't be turned on. It was the only oxygen tank available.
- The vital sign machine was three months past the date when it should have received preventative maintenance and an electrical safety check.
- The cabinet covering where sterile instruments were wrapped was peeling and cracked. Under the cabinet, empty cardboard boxes were stored on the floor in the same area where sterile instruments were wrapped. According to the report, "this had the likelihood to contaminate supplies which could cause an infection."
- Cardboard shipping boxes were stored with open patient supplies on the shelves. Cardboard boxes were on the shelf above the open sterile supplies.
- Open sterile supplies were stored near the floor where dust particles could contaminate them. In addition, cardboard shipping boxes containing patient belongings were stored on the floor in the same area where open sterile supplies were kept.
- Two suction machines had no preventative maintenance safety check stickers on them, meaning they were not being inspected or properly maintained. Staff told inspectors these machines weren't being used, but they did not have a "do not use" label and inspectors believed they "were available for patient's use."
- Cardboard shipping boxes with biohazard needles were stored on the floor in the same area where sterile supplies were kept.
- There were trash and dust particles in the area where open sterile supplies were stored.
- There was a mop bucket with dirty brown water sitting in the janitor's closet. A staff member didn't know when the bucket of water had last been used.
- Clean linen was observed on the floor of the laundry room.
- The biohazard waste storage room, where human tissue was kept, had an unsealed cement floor. This created a situation for blood to leak from the biohazard bags onto the unsealed cement floor, creating a surface that was impossible to clean and increasing the risk of transmitting infection.
- Temperature and humidity weren't monitored in areas where sterile instruments were stored. According to the inspection report, this could cause a fire hazard, the buildup of dust, and/or the growth of microbes.
- Sterile instrument packages were incorrectly sealed. According to the report, this had the potential to cause contamination and microbial growth. According to one staff member, "the girls assisting me did not have the knowledge to recognize that the peel pouches were not sealed or labeled correctly and that they would need further training."

<u>Staff</u>

- A staff member reached into a washing machine and handled dirty linen, potentially stained with blood and bodily fluids, without personal protective equipment.
- Staff failed to wear proper operating room attire during surgeries.
- The facility didn't know the hepatitis B status of half of its employees.

Medical Records and Labels

- Sealed packages of instruments weren't labeled correctly and were also improperly sealed.

Treatment of Patients

- Doctors didn't perform physical exams on patients prior to surgery. There was no documentation of exams for half of the patients whose charts were examined and inspectors were "unable to find evidence" that exams were done.
- Patients weren't evaluated by a physician or advanced practice registered nurse prior to being dismissed from the facility after surgery. An employee stated, "the physician completes their procedure and does not see them in recovery unless there is a complication." However, without an exam, it could be hard to determine if there was in fact a complication. Other employees confirmed patients weren't seen in recovery prior to going home.

Other

- The facility failed to store medication in a safe and secure area. Lidocaine vials were located in an unlocked storage area, where they could be accessed by unauthorized persons.

Fort Worth (Soutwest)

The health department document from 2016 can be found at:

www.problemsatplannedparenthood.org/texas-dallas-ft-worth

Highlights:

Clinic Conditions

- The facility "failed to ensure a safe and sanitary environment for surgical patients."
- The facility wasn't conducting proper maintenance on three suction machines. The facility was nevertheless performing surgery with these machines.
- Supplies in the emergency crash cart were expired.
- There were no oxygen tanks available in case of emergencies.
- Cardboard shipping boxes were stored with sterile patient supplies, creating a risk of contamination. A dirty feather duster was lying beside sterile supplies.
- A cardboard box containing biohazardous waste was also stored right next to the sterile supplies. According to the report, "this had the likelihood to contaminate the clean and sterile supplies from the waste products brought into the room and placed in the biohazard box."

- Trash and dust particles were on the floor of the room where sterile supplies were stored.
- There were exposed wires from an uncovered electrical outlet in the laundry room, creating a fire hazard. These wires were close to where water ran into the washing machine.
- The wall in the laundry room had areas where plaster was missing. This made it so employees couldn't clean the wall and created the risk of contamination of clean linens.
- Snacks for patients were kept in a cardboard box placed on a dusty and dirty cart.
- There was equipment that wasn't labeled or sorted to determine if it was clean or dirty.
- In the pharmacy, there were several carts covered with dust.
- Packages of instruments weren't sealed correctly, leaving the possibility of contamination.
- Staff didn't maintain the autoclave, which was used to sterilize dirty instruments. They failed to monitor pressure and temperatures. According to the report, this "had the likelihood to cause contamination and microbial growth in the sterile instrument packages." The printer on the autoclave hadn't been working for six months, so there was no way for staff to know if the autoclave had reached the proper pressure and temperature to sterilize the instruments.
- The facility failed to conduct a monthly examination of one of its two fire extinguishers.

Staff

- None of the nurses who were administering conscious sedation to patients had proper training.
- Staff didn't wear proper operating room attire in surgery.
- The facility didn't know the Hepatitis B status for half of its employees.

Treatment of Patients

- Doctors at the facility didn't conduct physical exams on patients before their surgery in every patient case reviewed. Staff could find no documentation or evidence that physical exams had been performed and couldn't provide evidence that they were.
- The facility had expired laminaria (sticks put inside women's bodies before abortions to open the cervix) and seemed to be using them on women.

Other

- The facility had no policy of surveillance techniques to minimize sources of infections. They didn't track infections of patients.

Houston

The health department documents from 2015 and 2017 can be found at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Clinic Conditions

- The biological indicator used on the autoclave wasn't properly tested. The autoclave was used to sterilize instruments. Inspectors determined that the biological indicator tests being conducted weren't valid.
- Medical equipment in the operating room was covered with rust and couldn't be disinfected.
- Packages of dilators marked as sterile had dime-sized brown spots on them. When questioned about the stains, a staff member admitted that the instruments weren't sterile and shouldn't have been labeled as such or stored with the sterile instruments.
- Instruments were improperly sterilized. Instruments were improperly packaged, preventing them from being properly sterilized.

Staff

- The doctor was operating on women without washing his hands. Staff members failed to wash their hands after handling dirty instruments.
- When a doctor was observed not washing her hands after surgery, she told inspectors, "Yes, I should do that, but because maybe sometimes if people are watching you, it's kind of overwhelming."
- Staff didn't have training on how to properly sterilize instruments. Three of the staff working in sterile processing had no documentation of training or competency.
- Staff didn't properly measure the amount of detergent per water used to clean instruments.
- None of the nurses administering sedation were officially trained to do so or had documentation of competency to do so. The Director of Nurses claimed that nurses administering sedation learned on the job, by observing others in a mentorship-type situation, but none of the employees administering sedation were formally trained.

Treatment of Patients

- Contaminated, unsterile instruments were used in surgery.
- Staff didn't clean the IV port prior to injecting medications into women

Stafford

The health department documents from 2019 can be found at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Highlights:

Clinic Conditions

- Hazardous chemicals and cleaning products were not stored in a secure manner.

Staff

- Two of the five staff providing direct patient care didn't have training or certification in CPR or basic life support.

Treatment of Patients

- The facility failed to develop and implement written discharge instructions. None of the patients had been given a list of potential complications to be aware of. They weren't instructed on what symptoms indicated an emergency and necessitated calling the facility or going to an emergency room. They weren't given an emergency number to call to reach a doctor in the event of a complication or if they had questions. The clinic staff didn't inform women of the number and location of the nearest hospital.
- The facility wasn't having women return for a follow up appointment after taking a medication that might put them in danger of suffering infection or hemorrhaging.

San Antonio

The health department documents from 2012, 2015 and 2019 can be found at:

www.problemsatplannedparenthood.org/texas-san-antonio

Highlights:

Clinic Conditions

- to the report, "the facility failed to follow its own procedures to maintain separation of contaminated and sterile supplies."
- Biological indicators used for monitoring the effectiveness of steam sterilizers were in the same refrigerator as medications. Biological indicators contain bacteria spores and, according to the inspection report, should be regarded as contaminated and should be stored apart from medication and sterile supplies.
- The medication refrigerator was kept in the dirty utility room.

- The facility failed to have signs posted which offered sex trafficking victims a hotline they could call for help. It was a legal requirement for them to be posted in patient bathrooms and consulting areas.

Other

- The facility allowed unlicensed staff to have access to the cabinet where controlled substances were kept. An unlicensed staff member had the keys to the cabinet and unlimited access to the narcotics.

Waco

The 2019 inspection report is entirely redacted, so the violations are unknown

Utah

The health department documents from 2012, 2015 and 2017 can be found at:

www.problemsatplannedparenthood.org/utah

Highlights:

- Hot water in patient areas was measured at temperatures that were too high, risking burns.
- There were no grab bars in the bathrooms for patients.
- The facility's communication room ceiling had two loose or missing tiles, creating a fire hazard.
- The facility didn't have emergency exit lighting. There was no back-up emergency light over the stairs, creating a hazard if the building needed to be evacuated.
- In another inspection, exit signs weren't lit, presenting a risk in case of an emergency.
- The facility failed to have smoke detectors in the required locations.
- Fire drills weren't conducted and documented properly.

Virginia

Charlottesville

The health department document from 2018 can be found at:

www.problemsatplannedparenthood.org/virginia

Highlights:

- The facility staff failed to ensure that medical records were stored in a secure area. Records containing personal information were observed lying on top of a shelf just inside a door, accessible to anyone who opened the unlocked door.
- Unsigned prescriptions for controlled substances were stored behind an unlocked door, where they could be accessed by unauthorized persons.
- Narcotics weren't kept locked up but were unsecured.

Richmond

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/virginia

Highlights:

- Surfaces weren't disinfected between patients.
- Staff failed to maintain procedures which prevented cross-contamination and transmission of infections.
- There was a sticky residue from tape on one of the exam tables that prevented the table from being properly disinfected between patients.
- Four of the seven recliners in the recovery room were dirty, with particles of food in crevices between the seat cushions and the sides. Staff admitted the recliners hadn't been disinfected between patients.
- Disposable absorbent padding wasn't changed between cases. Instruments and surgical supplies were placed on this padding, raising the risk of infection.
- Staff failed to wash their hands after changing out of contaminated gloves before putting on new gloves. They also failed to use hand sanitizer and didn't clean their hands after touching blood, bodily fluids, and dirty instruments.
- Inspectors witnessed a staff member place a dirty container that had been sitting on top of a biohazard box onto an exam table a woman was about to lie on.

Wisconsin

Milwaukee (Water Street)

The health department document from 2017 can be found at:

www.problemsatplannedparenthood.org/wisconsin

Highlights:

- The laboratory staff failed to monitor temperatures in the laboratory. Specimens and reagents need to be kept at a certain temperature to prevent them from being compromised. Fluctuating or too warm temperatures can prevent proper results from being obtained.
- The laboratory staff didn't follow the proper procedures for testing samples. Lab technicians didn't follow manufacturer's instructions while conducting tests with laboratory equipment.

Chapter 2

This chapter does not include deaths, which are listed separately. We include only cases since 2000, and only those where details of the allegations are known.

We use the plaintiff's last name to distinguish the cases, but the plaintiff's full name and the name of individual defendants are redacted in the excerpts on our pages. They are of course available in the documents on the Problems at Planned Parenthood website.

Alabama

Birmingham

Clark

The Court Document, Complaint and Factual Allegations, can be found at

www.problemsatplannedparenthood.org/alabama

Excerpt:

Page 4

12. On August 20, 2010, defendants performed an ultrasound showing estimated fetal gestational age of 8 weeks 4 days. . .

Page 5

17. On September 14, 2010, plaintiff presented to emergency department of BMC Princeton Medical Center in Birmingham Alabama with complaints of nausea, vomiting and left lower quadrant pain.
18. On September 14, 2010 following physical examination and ultrasound exam at the emergency department of BMC Princeton Medical Center, the ultrasound showed evidence of a 13-week gestation that was extrauterine involving left adnexa (fallopian tube), this finding prompted emergency admission of plaintiff for surgical intervention, pain management and treatments.
19. On September 15, 2010, at MBC-Princeton Medical Center, plaintiff underwent a laparoscopy with conversion to laparotomy in which plaintiff's left tube was removed with the 13-week fetus and placenta.

Mobile

The Alabama Department of Public Health Statement of Deficiencies can be found at:

www.problemsatplannedparenthood.org/alabama

Excerpt:

Pages 1-2:

Based on the review of the Alabama Code 1975, Title 26, Chapter 14, Reporting of Child Abuse or Neglect, facility's policies and procedures, medical record (MR), and interview, it was determined the facility failed to report reasonable suspected abuse or

neglect for a minor. This affected MR # 16 and had the potential to affect all patients served by this facility.

	Planned Parenthood in Mobile Failed to Report Possible Abuse of 14-Year-Old by Keith Lane, NBC News 15, August 26th 2015

Excerpt:

The Alabama Department of Public Health confirmed that the report is from their annual inspection in Mobile back in November 2014. The deficiency report details several incidents including a case involved a 14-year-old minor identified in the report as MR#16. According to the findings, the 14-year-old had recently received her second abortion from the clinic in four months and she already had two other children. It said there was evidence that she was "abused," but the incident wasn't reported to police at the time.

Under Alabama's state law, all hospital, clinic, doctors, physicians and professional health employees are "mandatory reporters" and must report when a child is "known or suspected of being a victim or child abuse or neglect"

California

El Cerrito

Trujillo

The court document and the legal summary below can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Filed May 1, 2018. Case No. MSC18-00885

Legal Summary from Trellis Law (references to Petition paragraphs removed)

Plaintiff's complaint is based upon medical treatment that she received from defendants on January 26, 2017. During that visit, plaintiff received an ultrasound and was told that she an intrauterine pregnancy. Plaintiff alleges that Weinstein was negligent because she did not consult with a medical doctor when the circumstances required it. As it turned out, however, plaintiff had an ectopic pregnancy, which required emergency surgery and hospitalization from January 30 to February 3, 2017. She was then hospitalized again from February 4 to either the 8th or 11th.

San Francisco

J.B.

The document, Dolan Law Firm Medical Malpractice, can be found at:

www.problemsatplannedparenthood.org/california-s-to-z

Excerpt:

$686,000 VERDICT, jury trial, J.B. v. Planned Parenthood, San Francisco Superior Court. A medical malpractice case in which Planned Parenthood Golden Gate ("PPGG") preformed an early first trimester abortion, failing to diagnose a twin pregnancy and aborting only one fetus and part of another. PPGG continued to see the patient and failed to perform pregnancy tests to diagnose her as still pregnant despite the fact that she had symptoms. A late second trimester abortion required the termination of her pregnancy in the fifth month. Medical Malpractice damages are capped in California.

Pasadena

Chidinma

	Planned Parenthood Pasadena Sued Over Allegedly Wrong 'Common Constipation' Diagnosis City News Service, *Pasadena Now*, August 22, 2023

Excerpt:

A former Planned Parenthood patient Monday sued the organization for medical malpractice, alleging she was incorrectly diagnosed with "common constipation" when she actually had serious issues that put her reproductive capability at risk . . .
Chidinma went to Planned Parenthood in March 2022 for a wellness exam and told her provider that she was having abnormally heavy vaginal bleeding, headaches, hormonal imbalance and other related discomforts and abnormalities, according to her suit . . .

Chidinma additionally told informed the provider that she had bloating and a possible mass in her abdomen, but was denied an ultrasound and told she had "common constipation," the suit states.

Chidinma argued that her condition was more serious and again requested the ultrasound and equivalent testing, but she was again turned down . . .

Chidinma's symptoms persisted for several months and worsened, so she returned to Planned Parenthood in January and asked again for an ultrasound, finding out for the first time that the facility did not have ultrasound equipment, the suit alleges.

Chidinma was granted a request to be examined by someone else and it took less than a minute for the new provider to diagnose that the plaintiff's uterus was sharply expanded and that masses were present that could have been found during the March 2022 Planned Parenthood office visit, the suit states.

Chidinma cried and contacted her insurance carrier from her car to obtain coverage from a different provider organization and she learned during her visit to the new facility that she had fibroids so large and advanced that her reproductive health was at risk and that non-surgical options she had in March 2022 were no longer available, the suit states.

Colorado

Colorado Springs

Byer

Filed February 6, 2013. The Complaint and Jury Demand can be found at:

www.problemsatplannedparenthood.org/colorado

Excerpts:

12. Upon Plaintiff's condition that she would receive anesthesia for pain through an I.V. for which Plaintiff would pay an additional fee, Plaintiff agreed to the surgical abortion . . .
14. However, before the I.V. was inserted and before the Plaintiff received any anesthesia, the Planned Parenthood Doctor [name unknown] began the procedure . . .
15. At this time, Plaintiff immediately told the Planned Parenthood Doctor to stop and that she did not want to go through with the abortion procedure because she had not received any anesthetic. Plaintiff also informed . . . that she believed this to be a sign she should not go through with the abortion. The Planned Parenthood Doctor did not stop, despite Plaintiff's request . . .
17. The Planned Parenthood Doctor then proceeded to use the vacuum machines while Plaintiff was fully awake and had not received any anesthetic despite their agreement. Plaintiff was forced to feel the full pain of the procedure against her will . . .
24. Upon Plaintiff's return home, it was evident the pain medication did not work . . . After approximately two (2) days Plaintiff just barely had enough strength to make it to the Emergency Room at Penrose Hospital . . .
25. The medical staff at Penrose informed Plaintiff she needed an emergency D&C . . .

27. Plaintiff remained in the hospital for approximately two (2) to four (4) days due to her weakness from fever and loss of blood. Most D&C patients leave the same day, which is evidence of Plaintiff's severe injury from Planned Parenthood's negligent procedure.

Connecticut

Danbury

Lafo

The full Malpractice Complaint can be found at:

www.problemsatplannedparenthood.org/connecticut

Excerpts:

5. On February 10, 2020, the plaintiff . . . presented to the Danbury Planned Parenthood for an evaluation after she received a positive home pregnancy test.
6. During her visit . . . the defendant . . . performed a transvaginal ultrasound which she read to show there was no fetus and just an empty sac at 6 weeks and 3 days gestation.
7. As a result of her reading of the ultrasound the defendant . . . recommended a medical abortion for what she determined to be a non-viable pregnancy prescribing Mifeprex and Misoprostol which the plaintiff took as instructed.
8. On or about February 12, 2020, at approximately 3:00 AM, after experiencing severe cramping and discomfort, the plaintiff delivered a deceased but intact male fetus with a weight of 474.5 grams consistent with a 22 week gestation age into a toilet at her home.

Hartford

Thompson

The full Malpractice Complaint can be found at:

www.problemsatplannedparenthood.org/connecticut

Excerpt:

10. As a direct and proximate result of the aforementioned departures from the standard of care, the plaintiff suffered the following serious and severe injuries:
a. Perforated uterus;
b. Perforated bowel;

c. Need for emergency hysterectomy;
d. Need for emergency bowel resection; and
e. Need for emergency unilateral salpingo-oophorectomy.

New Haven

Hackett

The full Malpractice Complaint can be found at:

www.problemsatplannedparenthood.org/connecticut

Excerpts:

3. At all times relevant herein, the defendant, Planned Parenthood of Southern New England . . . was located in New Haven, Connecticut . . .

4. On June 4, 2015, [Plaintiff] was seen at Planned Parenthood . . .

5. On June 18, 2015, [Plaintiff] returned to Planned Parenthood and Defendant . . . inserted an intrauterine contraceptive device (hereinafter referred to as "IUC" or "IUD"), known as Liletta, to prevent pregnancy. . .

7. On March 7, 2016, [Plaintiff] was seen at Planned Parenthood by Defendant . . . for an IUD check. Medical records from this visit document that the patient is "Happy with IUD, no menses, occasional spotting." Defendant . . . charted that she performed an examination of the female genitalia. Her notes of this examination include: "Cervix: no discharge per os or cervical motion tenderness and normal appearance and IUC string per os. Uterus: normal size and shape and mobile, non-tender, and no uterine prolapse" and "reassurance offered that IUD strings are correctly located and appropriate length." . . .

8. On June 27, 2016, [Plaintiff] was seen at Planned Parenthood by Defendant . . . because she had been feeling sick and nauseous for a few months. [She] reported that she did a home pregnancy test which yielded a positive result. Defendant . . . documented that she performed an examination of the female genitalia. Her notes of this examination included: "Uterus: mobile, non-tender, normal shape, no uterine prolapse and enlarged (20 wk size)." An office pregnancy test rendered a positive result. And office ultrasound was performed and interpreted by Defendant . . . as "indeterminate for pregnancy location," and questionable molar pregnancy. [Plaintiff] was sent to Hammers Imaging for a STAT ultrasound. The result was a "viable pregnancy of 31 weeks 3 days." The estimated date of delivery was August 26, 2016 an no definite IUD was identified . . .

11. Defendant . . . deviated from applicable standards of care in one or more of the following ways:

a. She failed to perform a full, thorough, internal examination . . . at the March 7, 2016 appointment and had she done so she would have determined that [Plaintiff] was approximately 14 weeks pregnant at that time . . .

Washington D.C.

Butler

Filed February 12, 2008, settled February 24, 2009. Court documents can be found at:

www.problemsatplannedparenthood.org/washington-dc

Excerpts from Complaint:

II. STATEMENT OF FACTS

14. That within twenty-four (24) hours of her discharge from Defendant's facility after the termination procedure, the minor Plaintiff . . . became very ill.
15. That on or about September 8, 2006, the minor Plaintiff . . . presented to the emergency room at Civista Medical Center with severe abdominal pain and peritonitis.
16. That a CT scan of the minor Plaintiff's abdomen on September 8, 2006, showed a significant amount of bleeding in the abdomen with free air. Consequently, the minor Plaintiff underwent immediate emergency surgery to evacuate the large abdominal bleeding the day after the termination procedure performed by Defendant . . .
17. That during the surgery on September 8, 2006, it was discovered, intra-operatively, that the minor Plaintiff . . . had suffered the following injuries as a direct and proximate result of the termination procedure performed by Defendant . . . :
    a. severe abdominal bleeding;
    b. severe vaginal injury;
    c. severe injury to the cervix;
    d. significant uterine perforation; and
    e. a small bowel tear.

18. That a significant portion of the fetus that was allegedly removed from the minor Plaintiff . . . during the pregnancy termination performed by Defendant, was also found inside the minor Plaintiff's abdomen on September 8, 2006.
19. That the minor Plaintiff . . . is now infertile for the rest of her life due to the injuries sustained . . .

Note:

The petition states that plaintiff was 13 years old and became pregnant due to a rape. There is no indication in the petition that the Planned Parenthood staff collected evidence to help identify the rapist with DNA, and no further information on whether he was ever charged.

Delaware

The full Malpractice Complaint can be found at:

www.problemsatplannedparenthood.org/delaware

Moore

Excerpts:

7. . . . an ultrasound was conducted and Plaintiff . . . was told she was under five (5) weeks pregnant and would not require a surgical abortion, which gave the impression that Defendant Planned Parenthood established an intrauterine pregnancy.

8. . . . Plaintiff . . . was given one (1) pill to be taken by mouth, instructed to go home and on the 17th of December, after having a prescription filled for additional pills, she was instructed to insert four (4) of the pills into her vagina and that she would cramp and bleed for the next seven (7) or eight (8) days producing loss of the baby.

9. On about January 5, 2005, Plaintiff . . . had a follow up visit with Defendant, Planned Parenthood, and at that time had her urine checked through use of a "dip test", and was subsequently informed . . . that she was no longer pregnant.

10. At the same time and place, Plaintiff . . . was given an ultrasound . . . and she was again assured that she was no longer pregnant and that the medical abortion had been successful.

11. By about January 7, 2005, Plaintiff . . . was having problems urinating, was bloated and began experiencing severe pain in her body, and especially in her back and stomach.

12. On about January 8, 2005, Plaintiff . . . was rushed to Kent General Hospital where she again underwent a urine test which showed positive for pregnancy and an ultrasound which confirmed that there was an acute ruptured ectopic pregnancy in her right fallopian tube diagnosed as ruptured right ampullary/corneal ectopic gestation with Hemoperitoneum (an effusion of blood into the peritoneal cavity) requiring an emergency laparoscopy and surgical removal of the right fallopian tube (salpingectomy).

Illinois

Chicago

Castro

The full Malpractice Complaint, and the recording of the 911 dispatch call for May 24, 2018, can be found at:

www.problemsatplannedparenthood.org/illinois-chicago

Excerpts:

4. On May 24, 2018, [Plaintiff] was present at Planned Parenthood, 1200 North LaSalle, Chicago, Illinois, for the implantation of intrauterine contraception ("IUC") . . .
9. . . . before the IUC procedure, a Planned Parenthood healthcare professional told [Plaintiff] that she may experience side-effects from the procedure, including, but not limited to, dizziness and cramping.
10. . . . shortly after the insertion of the IUC, [Plaintiff] experienced dizziness and informed the Planned Parenthood healthcare professional present at the time of the dizziness.
11. . . . following her complaints of dizziness [Plaintiff] was left alone and unmonitored.
    . . . while unmonitored, [Plaintiff] lost consciousness and fell off the table to the ground, striking her head and neck area, and resulting in a broken neck.

Massachusetts

Boston

Case 1: Cullen

The full Malpractice Complaint, handwritten by plaintiff on a Civil Case Cover Sheet In 2018, can be found at:

www.problemsatplannedparenthood.org/massachusetts

Docket Number: SUCV2012-03299

Excerpt:

In August of 2012, I . . . received a suction abortion at Planned Parenthood. 3 hours after leaving the clinic I was taken ch ambulance to Mass General Hospital in Boston. I was told the abortion had been done wrong. I had suffered extreme blood loss which had caused me to black out when I left the clinic. Due to losing consciousness after the abortion I fainted hit my head 2 times once in the front breaking 2 of my teeth and splitting by chin open. I needed 4 stiches in my chin which left a life-long permanent scar. I suffered a concussion, sprained neck, which has caused me to miss many days of work. I suffered from PTSD which has prevented me from going to Boston where the incident happened. I am permanently physically + mentally damaged due to this malpractice.

Case 2: Davis

The full Malpractice Complaint, Affidavit, and Offer of Proof can be found at:

www.problemsatplannedparenthood.org/massachusetts

Excerpt from the Complaint:

9. On or about February 4, 2016, the plaintiff, then twenty-one (21) years old and of limited financial means, presented to . . . Planned Parenthood in Boston, Massachusetts for a first-term surgical abortion.
10. On or about that date, [the doctor] confirmed the ten (10) week gestational age of the pregnancy, performed the surgical abortion procedure with the assistance of ultrasound guidance (due to difficulty with dilation), then purportedly conducted a gross tissue exam of the removed products, declared the pregnancy “terminated” and discharged the plaintiff . . .
16. Neither [the doctor] or anyone else at Planned Parenthood ever advised the plaintiff that prolonged bleeding and severe abdominal pain/cramping could be a sign that she had RPOC [Retained Products of Conception].
17. During the days following the . . .procedure, the plaintiff suffered significant and continuous bleeding, abdominal pain and cramping.
18. Notwithstanding that Planned Parenthood had correctly recorded the plaintiff’s phone number . . . neither [the doctor] or anyone else from Planned Parenthood ever called her to obtain her post-abortion status, or to schedule a follow-up appointment.
19. Moreover, the plaintiff’s repeated phone call messages to [the doctor] and/or Planned Parenthood during the two (2) week period following her procedure were never returned.
20. Her debilitating symptoms having not resolved, and having received no reply . . . the plaintiff presented at the CHA Cambridge Hospital Emergency Department on/or about March 15, 2016 . . .

25. Her symptoms having not abated, the plaintiff ultimately presented at the MGH Emergency Department on April 4, 2016, where a gynecological consultation summarily advised the need for an US, which I turn revealed to the plaintiff, for the first time, that the abortion procedure at Planned Parenthood had resulted in substantial RPOC; the plaintiff received appropriate medical treatment at MGH and was discharged . . .
37. As a direct and proximate result of said acts and omissions of Planned Parenthood . . . the plaintiff suffered significant pain, mental anguish and disability, was deprived of a more favorable medical outcome, and suffered unnecessary hospitalization and medical expense.

Worcester

Casas

The full Malpractice Complaint, Amended Complaint, and 2nd Amended Complaint can be found at:

www.problemsatplannedparenthood.org/massachusetts

Excerpt from Second Amended Complaint:

5. On or about March 12, 2015, [the doctor] performed the first step in a two-sept abortion at the Planned Parenthood clinic in Worcester by softening the cervix.
6. This first-step placed Ms. Casas at risk for vaginal delivery of the fetus.
7. Neither the doctor] nor [the nurse], who discharged [Plaintiff] ever informed her that she was at risk for vaginal delivery of the fetus . . .
9. Later in the afternoon on the same day she was discharged, [Plaintiff] began experiences severe labor type pains and called Planned Parenthood looking for advice and instructions. [Plaintiff] was told by a nurse . . . to take the pain medication that she had been prescribed; she was not advised that she was at risk for a vaginal delivery and she was not instructed to seek medical attention.
10. [Plaintiff] called Planned Parenthood later that evening, after hours, and was connected to an unknown person acting as an agent, servant and/or employee of Planned Parenthood. [Plaintiff] again explained that she was having severe stomach pains and again was advised to take the medications that had been prescribed to her. She was not advised that she was at risk for a vaginal delivery and she was not instructed to seek medical attention.
11. The following morning [Plaintiff] delivered the fetus in the bathroom of her home, causing her physical pain and severe emotional and mental trauma.

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Michigan

Ann Arbor

Rygwelski

The full Petition can be found at:

www.problemsatplannedparenthood.org/michigan

Excerpt:

27. On September 25, 2014, Plaintiff . . . was admitted to PLANNED PARENTHOOD seeking confirmation of pregnancy and also because she was experiencing vaginal discharge and odor. Her pregnancy was confirmed but an ultrasound was not performed in order to assess viability and gestational age.
28. On October 1, 2014, Plaintiff . . . returned to PLANNED PARENTHOOD. A biopsy of her cervical tissue was performed and her specimen was sent to Quest Diagnostics for testing.
29. On October 3, 2014, the lab results indicated that the cervical tissue was a product of conception. The tissue was actually an endocervical polyp. Defendant . . . misdiagnosed Plaintiff's signs and symptoms as inevitable abortion. Defendant . . . wrongfully prescribed misoprostol and failed to perform an ultrasound to assess viability and gestational age of the fetus.
30. Plaintiff . . . did not pass any tissue after the first course of misoprostol.
31. On October 3, 2014, Plaintiff . . . was given a second course of misoprostol. No tissue was passed after the second course of misoprostol.
32. On October 7, 2014, Plaintiff . . . saw her primary doctor . . . After performing a physical examination, Dr. . . . discovered polypoidal tissue in her cervix that was consistent with an endocervical polyp. An ultrasound examination was performed at Dr. . . . ‘s office and it revealed a viable intrauterine pregnancy at 7 weeks and 2 days with an expected date of conception on May 19, 2015.
33. On October 10, 2014, Defendant . . . advised Plaintiff . . . that she should have a therapeutic abortion due to teratogenetic effects of misoprostol.
34. On October 20, 2014, Plaintiff . . . had an abortion performed by a third party.
35. Agents of PLANNED PARENTHOOD misdiagnosed Plaintiff . . . with an inevitable abortion. Agents of PLANNED PARENTHOOD should have performed an ultrasound to determine the status of the pregnancy and should not have prescribed misoprostol to a patient who desired to continue her pregnancy. As a result, Plaintiff’s pregnancy was wrongfully terminated.

Nebraska

Lincoln

Roe

The full Complaint can be found at:

www.problemsatplannedparenthood.org/nebraska

Plaintiff uses Jane Roe as a pseudonym to protect her privacy.

Excerpt:

10. . . . Plaintiff was laid back on an examination table and her feet were placed up in stirrups. She then felt an injection into her cervix. The shot was painful and she cried out and told the attendants and Defendant [doctor] of the painful nature of the injection. Shortly thereafter, Plaintiff heard a suctioning sound and felt pressure in her uterus. Plaintiff immediately complained of excruciating pain and told [the doctor] that something was terribly wrong and to stop the procedure. Defendant refused. Plaintiff continued to complain of pain and continued to plead for the procedure to be stopped. Defendant . . . refused and continued moving the suctioning device in the Plaintiff's uterus. Plaintiff told Defendant . . . that the pain was unbearable. Rather than stopping the procedure or providing Plaintiff with pain medication, Defendant . . . told the Plaintiff, "We can't stop," and instructed the attendants to hold her down . . .
12. After the procedure, Plaintiff was in acute pain, nauseous, and bleeding from the vagina. A pad was placed over Plaintiff's vaginal area . . . Plaintiff was then asked to walk over to the recovery room. Plaintiff advised employees that she was in too much pain. She was then assisted to the recovery area . . . When Plaintiff continued to complain of pain, she was provided a heating pad. Plaintiff was not otherwise provided with additional medical treatment at that time . . . Plaintiff was given a prescription for 800 mg. Ibuprofen to be filled after she left the center . . .
14. . . . In attempting to get to the bathroom, Plaintiff passed out, fell to the floor, and suffered a seizure type event. Plaintiff was on the floor for approximately 10 to 15 minutes during which time Planned Parenthood's medical treatment of the Plaintiff consisted of placing numerous blankets on her because she was complaining of being cold . . . While on the floor, Plaintiff suffered a second seizure type event. Then Plaintiff, with assistance, was returned to one of the recliner chairs where she suffered a third seizure, this one more acute than the others with Plaintiff's body stiffening and her eyes rolling up into her head. Plaintiff's condition continued to deteriorate, and at 4:38 PM Lincoln Fire and Rescue was called . . .

16. At Bryan LGH East, Plaintiff underwent life-saving emergency surgery. During surgery, the hospital physician discovered that Plaintiff had suffered a catastrophic perforation of her uterus . . . [The doctor] had cut into and through the sidewall of Plaintiff's uterus and had suctioned tissue from the surrounding area thereby ripping through uterine vessels and ligament . . .
18. Due to the "extensive nature of the trauma" . . . they preformed an emergency hysterectomy . . .
19. Neither of the operating physicians had ever seen such extensive wounds to the female uterus and surrounding tissues . . .
20. . . . Plaintiff required multiple blood transfusions at the hospital. Her final blood loss was approximately 4 liters which is equivalent to 80 percent of the average woman's total blood volume.
21. Had she not received the emergency care of the paramedics and the life-saving care of the Bryan LGH medical team when she did, Plaintiff would likely have hemorrhaged to death.

COUNT I: NEGLIGENCE . . .

COUNT II: BATTERY

23. Plaintiff withdrew her consent when she told the Defendants she was in severe pain and ordered them to stop the procedure. By failing to heed the requests of the Plaintiff to stop, and by physically restraining her against her will, Defendants committed a battery upon the Plaintiff.

New Mexico

Albuquerque

Griego

The full Complaint and Amended Complaint can be found at:

www.problemsatplannedparenthood.org/new-mexico

Suit: Tubal Ligation Causes Injury
by Olivier Uyttebrouck, *Albuquerque Journal*, December 15, 2012

Excerpt:

An Albuquerque woman alleges in a lawsuit that she required emergency surgery for a perforated bowel three days after she received a tubal ligation at a Planned Parenthood of New Mexico clinic.

Planned Parenthood and two physicians named in the lawsuit deny responsibility for the alleged injury.

Anathea Griego also contends she became pregnant seven months after receiving the tubal ligation, which is intended to make a woman sterile. She is expecting in January, the suit said . . .

Griego contends the physicians perforated her bowel when she received the tubal ligation on Aug. 29, 2011. She sought treatment for abdominal pain on Sept. 1, 2011, at the University of New Mexico Hospital, where she received emergency surgery.

New York

Albany

Alston

	Lawsuit: Capital Region hospitals failed to help woman after botched abortion by Rachel Silberstein, *The Times Union*, September 29, 2022

Excerpt:

An Albany woman is suing Upper Hudson Planned Parenthood and the Capital Region's largest hospital systems for allegedly neglecting to provide her medical care and guidance after a failed abortion – which she said resulted in weeks of pain, extreme blood loss and, eventually, a premature birth . . .

Alston encountered logistical challenges due to an unstable housing situation and likely racial bias, as studies show that women of color are far more likely (than white women to experience life-threatening complications in pregnancy and have their medical concerns dismissed by physicians.

	Albany woman sues three healthcare providers after botched abortion by Tessa Bentulan, News *Channel 13, WNYT,* October 5, 2022

Excerpt:

Alston immediately called Upper Hudson Planned Parenthood to schedule an abortion.

"I thought everything done and said," Alston said. "Days go by. I'm still heavily bleeding, pain in my stomach, just nauseous and just a lot of heavy bleeding."

Her pregnancy had not terminated.

"Planned Parenthood had no process for checking to make certain that the suction abortion was successful," said Lewis Oliver, Alston's attorney.

Oliver said the next few months were agonizing . . .

Her whole ordeal is detailed in a 55-page lawsuit. It claims that just three weeks after her botched abortion, she went to her regular OB-GYN at St. Peter's because of the continued bleeding and debilitating pain. Another test confirmed she was still pregnant at about 15 weeks. Planned Parenthood told her the bleeding, pain, and a positive test were all normal.

Hempstead

The full Summons and Complaint, Conference, and Defense Answer can be found at:

www.problemsatplannedparenthood.org/new-york

D'Avanzo

from Complaint:

34. Contrary to accepted standards of medical treatment, the defendants . . . PLANNED PARENTHOOD . . . performed a procedure for the termination of pregnancy, negligently and improperly a dilation and curettage, failed to properly remove the products of conception . . . failed to take steps to ensure that the products of conception had been removed . . . failed to send the biologic material removed . . . for analysis and pathological examination . . . failed to properly examine plaintiff, failed to properly perform repeat examinations; failed to properly preform sonograms on plaintiff; failed to determine that plaintiff had an ectopic pregnancy . . . failed to properly schedule follow-up visits for plaintiff; failed to order and perform appropriate diagnostic and laboratory tests for plaintiff, and were otherwise negligent . . .

Manhattan

Case 1: Buchanan

The full Complaint and following letter can be found at:

www.problemsatplannedparenthood.org/new-york-city

Excerpt from Complaint:

29. That the foregoing treatment [on May 12, 2015] and management of the plaintiff . . . by the defendant . . . was performed in a careless, negligent, and improper manner . . . including the failure to properly evaluate or diagnose cervical bleeding and cancer thereby causing the plaintiff . . . to sustain severe injuries and dangers . . .
30. That by reason of the foregoing, the plaintiff . . . was severely injured and damaged, rendered sick, sore, lame and disabled, sustained severe nervous shock and mental anguish, great physical pain and emotional upset, some of which injuries are permanent in nature and duration, and plaintiff will be permanently caused to suffer pain, inconvenience, and other effects of just injuries; plaintiff incurred and in the future will necessarily incur further health care facility and/or medical expenses in an effort to be cured of said injuries; and plaintiff has suffered and in the future will necessarily suffer additional loss of time and earnings from employment . . .

Content of Letter, March 19, 2018

Please be advised that plaintiff . . . died on February 24, 2018. We request that action be marked Stayed. Our Office will commence proceedings to appoint an administrator of the estate.

Case 2: Burton

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york-city

Excerpt:

78. That on or about the 21st day of September, 2004, the Defendant . . . improperly handled the post-operative care of Plaintiff at PLANNED PARENTHOOD, resulting in injuries, including but not limited to, a uterine perforation, need for surgical intervention, hematoma and a permanent left leg neuropathy.

79. That during all of the procedures and treatment rendered to the Plaintiff, the Defendants departed from acceptable standards of medical care to the Plaintiff.

80. That the Defendants caused Plaintiff to sustain serious injuries, including but not limited to, a uterine perforation, exploratory laparotomy, repair of a uterine perforation, infection, and a lumbosacral plexus neuropathy

Case 3: Pusey

The full Complaint and Stipulation can be found at:

www.problemsatplannedparenthood.org/new-york-city

Excerpt from Complaint:

15. That the defendants PLANNED PARENTHOOD . . . were negligent and committed malpractice in performing surgery in a negligent manner; in negligently perforating the uterus; in negligently lacerating, traumatizing and injuring the left uterine artery; in negligently causing massive hemorrhage and shock; in rendering negligent post-operative monitoring, care and treatment; in failing to exercise proper supervision . . .
16. That by reason of the foregoing, the plaintiff was proximately caused to sustain severe and permanent personal injuries, pain, suffering loss of enjoyment of life, mental anguish, cosmetic disfigurement, economic and pecuniary damages.

Case 4: Richards

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york-city

13. That on or about April 8, 2004, plaintiff was admitted to SUNY Downstate Medical Center where she was diagnosed with a right ruptured ectopic pregnancy and was required to undergo a diagnostic laparoscopy, exploratory laparotomy, evacuation of hematoma, right partial salpingectomy, and lysis of adhesions.

14. That defendants departed and deviated from good and accepted gynecological and obstetrical practice in the care and treatment rendered to plaintiff and that as a result of the negligent and careless treatment rendered to the plaintiff, plaintiff sustained serious injury and was required to undergo hospitalization and procedure and, upon information and belief, further hospitalizations and procedures may be required . . .

16. That defendants were negligent and careless . . . in failing to adequately test and exam plaintiff and diagnose an ectopic or tubal pregnancy . . .

17. By reason of the foregoing, plaintiff sustained severe and serious personal injuries; was caused to suffer severe physical pain and mental anguish as a result thereof; and many of the injuries are of a permanent and lasting nature; that plaintiff was confined to bed and home and hospital as a result thereof; and was incapacitated from attending to her usual duties and activities.

New Rochelle

Baker

The full Poor Person Order PSLR 1101(d) can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt handwritten by plaintiff in the form:

10. Briefly stated, the facts of my case are as follows:

Nerve damage, and permanent cervix damage. Painful intercourse, abdominal pain, and vaginal bleeding. Pain and suffering. Discomfort, and delay in work and daily activities.

Newburgh

Sampson

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt:

30. That at all times hereinafter mentioned, including on or about January 14, 2016 and March 24, 2016, and prior and subsequent thereto, the defendant PLANNED PARENTHOOD OF THE MID-HUDSON VALLEY, INC. d/b/a NEWBURGH HEALTH CENTER . . . was/were negligent, careless, unskillful and committed acts and omissions which constituted medical negligence and medical malpractice in connection with the medical, gynecological and obstetrical care rendered to plaintiff, in the following manner: in deviating from good and accepted medical practices which were prevailing in the community; in failing to undertake and administer proper gynecological and obstetrical care; in failing to properly and adequately diagnose pregnancy; in failing to properly and adequately perform a pregnancy test and in failing to timely act upon same; in failing to timely recognize, heed, appreciate and act upon the plaintiff's complaints, signs and symptoms; in failing to timely recognize, heed, appreciate and act upon signs of pregnancy; in failing to timely refer the plaintiff for prenatal care and diagnostic testing; in failing to undertake and administer proper prenatal care and diagnostic testing and practice; in negligently administering contraindicated medications and/or chemical agents; in administering medications and/or chemical agents in excessive and/or contraindicated dosages; in negligently administering Depo Provera birth control without testing

the plaintiff for pregnancy and while plaintiff was pregnant; in failing to obtain and/or arrange for the necessary and indicated specialist consultations; in failing to timely undertake and administer proper examinations and testing; in failing to assign and provide competent medical staff or to supervise its medical staff; and by other negligent acts and/or omissions; and by all of the foregoing did thereby proximately cause the severe injuries and conditions and associated direct complications and pain and suffering sustained and suffered by the plaintiff.

Smithtown

Thomas

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt:

This is a medical malpractice action wherein the plaintiff . . . alleges that during the performance of a second trimester abortion on April 18, 2009, the defendant, Planned Parenthood Hudson Peconic, Inc., by its staff, negligently perforated her uterus, resulting in her having to undergo an hysterectomy and suffer other permanent injury.

Ms. Thomas testified that she went to the West Islip Planned Parenthood on about April 15th or 16th 2009 for an abortion of her third pregnancy, had a blood test and applied for health insurance which covers the procedure and a three month period thereafter. She was referred to the Smithtown Planned Parenthood on April 18, 2009, as she was told she was too far along in her pregnancy to take the pill for the abortion at the West Islip Planned Parenthood office. She believed she was about 11 or 12 weeks pregnant. When she arrived at the Smithtown location, she showed the staff her 10 and filled out some paperwork for insurance . . .

She then had a sonogram and was advised that she was about thirteen and a half to fourteen weeks pregnant. Thereafter, she had some blood work performed . . . she went into a room where she was seen by [the doctor] and a nurse who gave her some pills to soften her uterus or cervix . . . She was placed on a table, and an intravenous was started. She then felt [the doctor] insert a "metal thing" into her vagina. When she started to feel a sharp pain, she told the doctor to stop, but he advised her that the procedure was already started and that he could not stop. She testified that shortly after that, the doctor advised her that there was "just a minor complication," and that he was calling Stony Brook Hospital. The next thing she knew, the paramedics were at her side. When they moved her she felt a gush of blood. Upon arrival to Stony Brook University Hospital, she was given a partial hysterectomy . . .

Spring Valley

Acocella

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt:

23. Defendant . . . was negligent in the care rendered . . . in failing to heed or appreciate the significance of the signs and symptoms exhibited by Plaintiff; in improperly prescribing medication; in improperly administering medication . . . in failing to timely refer Plaintiff to specialists, in failing to take a proper medical history of the Plaintiff; in failing to properly test the Plaintiff prior to prescribing, administering, and/or providing medication the Plaintiff . . .
28. Defendant . . . failed to disclose and/or inform Plaintiff of the risks associated with the medication . . . and of the alternatives thereto and the reasonably foreseeable risks and benefits association therewith as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting said Plaintiff to make a knowledgeable evaluation.
29. A reasonably prudent person in Plaintiff's position who had been fully informed would not have undergone the treatment . . .

White Plains

Jane Doe

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt:

49. On May 4, 2020, Defendant . . . prescribed the two-medication regimen of Mifeprex and misoprostol to terminate Plaintiff's pregnancy.
50. Plaintiff did not sign the required Patient Agreement Form, or any other form.
51. Defendants failed to conduct a physical exam of any type on Plaintiff, let alone a bimanual pelvic exam or abdominal exam.
52. Defendant failed to conduct an ultrasound on Plaintiff.
53. Plaintiff began her regimen of Mifeprex and misoprostol on May 4, 2020.
54. That evening, Plaintiff began experiencing painful cramping and pressure.
55. Plaintiff went into full labor in the early morning hours of May 5, 2020.

56. Plaintiff experienced extreme and painful accelerated changes to her body, including a vaginal laceration or tear, as the delivery progressed.

57. At approximately 3:00 am, while sitting on the toilet, Plaintiff gave birth to a fully formed, stillborn baby boy named J.T.

58. Plaintiff was shocked and traumatized when she saw the lifeless, fully-formed baby in the toilet covered in mucous, blood, and the placenta.

59. The next morning, Plaintiff advised Defendants about the ordeal. Plaintiff described the size of J.T.'s body to the Defendants. She described his size as the length of her forearm, not including his legs. Defendant . . . repeatedly asked whether the body was the size of a fist, but Plaintiff and her mother corrected her.

60. Instead of directing Plaintiff to the nearest emergency room, and despite knowing that J.T. was a fully-formed baby, Defendants directed Plaintiff to bring J.T. across county lines to Dr. [the doctor] at the White Plains Center for examination of both J.T. and herself.

61. At the White Plains Center, [the doctor] performed an ultrasound and physical exam on Plaintiff and also examined J.T.

62. Defendants determined that J.T.'s length and femur size were consistent with that of a thirty-three to thirty-six week old baby.

63. Defendants advised Plaintiff that they would dispose of J.T., further upsetting Plaintiff and her family.

64. Plaintiff, just hours post-partum and in shock, was made to wait for many hours at the White Plains Center.

65. Defendants told Plaintiff not to call law enforcement.

66. Plaintiff refused to allow Defendants to dispose of J.T. and a family member contacted law enforcement authorities for assistance.

67. Defendants made misleading statements to law enforcement, including the indisputably untrue statement that Plaintiff was "examined" and that Plaintiff decided on her own to bring J.T. across county lines.

68. J.T. was taken to the Westchester County Morgue.

69. J.T. was a fully formed and otherwise healthy baby.

70. Plaintiff had no intention of aborting a near-term baby, did not consent to the termination of a near-term baby, and would not have aborted a near-term baby or any baby after her first trimester.

71. An autopsy was performed on J.T. on May 7, 2020.

72. The cause of J.T.'s death was determined to be a "medically induced termination of pregnancy of a 30-week fetus."

73. As a result of Plaintiff's ordeal, she has endured significant stress, trauma, emotional anguish, physical pain, including laceration and an accelerated labor and delivery unaided by medication, lactation, soreness, and bleeding.

Chapter 3

We only report what can be documented by sources who are not Planned Parenthood opponents. Dispatch audio recordings and paper documents were received through official agencies and are available on the Problems at Planned Parenthood website.

Alabama

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/alabama

Mobile

February 23, 2017

California

Orange

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/california-g-to-r

February 22, 2013
May 9, 2013
January 16, 2021
February 13, 2021

Walnut Creek

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/california-s-to-z

May 14, 2019
September 15, 2020
May 14, 2021
May 21, 2021
July 23, 2021

Colorado

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/colorado

Aurora

September 24, 2022

Denver (Park Hill Center)

October 26, 2012
March 5, 2013
January 8, 2016
April 15, 2016
August 13, 2016
August 31, 2016
November 3, 2016
July 28, 2022
December 8, 2022

Fort Collins

January 7, 2023

Delaware

Wilmington

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/delaware

February 8, 2013
February 16, 2013

Illinois

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/illinois

Aurora

December 24, 2018
January 12, 2019
March 12, 2019
November 16, 2019
April 22, 2020
May 27, 2020
December 18, 2021
September 24, 2022

Chicago, Near North Center

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/illinois-chicago

February 10, 2016
March 23, 2016
April 7, 2016
April 25, 2016
May 21, 2016
June 16, 2016
August 29, 2016
November 1, 2016
October 4, 2017

November 16, 2017
May 24, 2018
July 5, 2018
July 27, 2018
September 5, 2018
September 11, 2018
October 6, 2018
March 21, 2019
October 30, 2019
November 19, 2019
July 10, 2020
July 15, 2021
January 20, 2023
January 25, 2023

Fairview Heights

December 19, 2019

Flossmoor

December 14, 2018
November 12, 2019
May 8, 2020
October 9, 2020
May 23, 2023
July 13, 2023
July 25, 2023
December 22, 2023

Springfield

January 8, 2020
May 27, 2020
June 3, 2020
August 6, 2020
November 19, 2020
February 4, 2021

Indiana

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/indiana

Indianapolis, Georgetown

November 2, 2012

Massachusetts

Written documents can be found at:

problemsatplannedparenthood.org/massachusetts

Boston

May 19, 2018
May 30, 2018
July 5, 2018
September 7, 2018
September 11, 2018
October 19, 2018
November 28, 2018
February 4, 2019
April 20, 2019
April 23, 2019

Maryland

Annapolis

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/maryland-annapolis-baltimore

October 24, 2016

Baltimore

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/maryland-annapolis-baltimore

December 7, 2018
October 2, 2019

Michigan

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/michigan

Flint

August 30, 2023

Kalamazoo

July 4, 2016
September 10, 2015
October 29, 2022

Lansing

March 15, 2018

Traverse City

October 27, 2023

Missouri

Written documents can be found at:

problemsatplannedparenthood.org/missouri

St. Louis

MO St Louis List of EMS Calls January 2009-April 6, 2016

P1 Urgent Response: 50
P2 Urgent on the Quiet Response: 2
P3 On the Quiet Response: 6

MO St Louis List of EMS Calls November 15, 2016-November 15, 2018

P1 Urgent Response: 7
P3 On the Quiet Response: 2

North Carolina

Audio of calls to dispatch an ambulance and/or written documents can be found at:

problemsatplannedparenthood.org/north-carolina

Chapel Hill

February 26, 2022
October 7, 2022
December 8, 2022
January 28, 2023

Ohio

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/ohio

Cincinnati

February 20, 2015
July 27, 2017

Columbus

October 9, 2015

Oregon

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/oregon

Salem

November 14, 2014

Pennsylvania

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/pennsylvania

West Chester

October 21, 2022

Rhode Island

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/rhode-island

Providence

June 11, 2014

South Carolina

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/south-carolina

Charleston

March 12, 2021

Columbia

April 22, 2022

Texas

Austin

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/texas-austin/

January 25, 2019
July 14, 2020

Houston

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/texas-houston-stafford

August 23, 2012
December 14, 2013
January 31, 2015
February 6, 2015
February 25, 2015
February 26, 2015
August 4, 2015

Virginia

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/virginia

Virginia Beach

October 14, 2011
April 7, 2017

Washington

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/washington

Lynnwood

March 12, 2023

Wisconsin

Audio of calls to dispatch an ambulance can be found at:

problemsatplannedparenthood.org/wisconsin

Madison

August 9, 2016

Chapter 4

California

Contra Costa

Tran

	Suit Links Death to 'Abortion Pill'" By Jennifer Muir, *Orange County Register,* October 7th, 2005.

Excerpt:

The husband of a Fountain Valley woman who died after taking the so-called abortion pill RU-486 has sued the drug's manufacturers and a local Planned Parenthood, accusing them of not warning her of the drug's risks . . .

Tran died Dec. 29, 2003 – six days after beginning the drugs' cycle. She was 22. An autopsy revealed evidence of sepsis, an illness caused by infection in the bloodstream, according to the complaint.

The Federal Drug Administration in July issued a public health advisory warning after four women in California, including Tran, died from sepsis after taking the drugs. The first U.S. death was reported in September 2003; a death in Canada was reported in 2001 . . .

Also named is Planned Parenthood of Orange and San Bernardino Counties . . Tran, a former education student at Santa Ana College, received the drugs Dec. 23, 2003, at the Planned Parenthood in Costa Mesa . . . Had she known of the risks, she would not have taken the drug or would have gotten the medical attention necessary to save her life, the lawsuit said.

Hayward

Patterson

	"Monty Patterson Learns about RU-486 the Hard Way" By Julian Guthrie*, The San Francisco Chronicle,* December 5th, 2011.

Excerpt:

It was just after 9 a.m. on Sept. 17, 2003, when Monty Patterson got the call from the hospital. His daughter was in intensive care, and Patterson, a construction supervisor working on a home in the Oakland hills, was told to hurry.
At ValleyCare Medical Center in Pleasanton, Patterson, a divorced dad, was informed that Holly, who had turned 18 three weeks earlier, had an infection from an "incomplete abortion." The doctor said Holly had taken the abortion pill Sept. 10, and was in septic shock . . .

Efforts to save the vivacious teenager with the blond hair and bright blue eyes failed. She died shortly before 2 p.m.

	"Monty Patterson Critical of Planned Parenthood After Daughter's Death" By Carly Schwartz*, Huffpost,* December 6th, 2011.

Excerpt:

On September 17, 2003, Monty Patterson rushed to ValleyCare Medical Center in Pleasanton, Calif., where his 18-year-old daughter, Holly, was suffering from septic shock brought on by a medical abortion. Five hours later, Holly was dead . . .

Holly had visited a Planned Parenthood center a week earlier seeking RU-486 — a medical abortion pill — but the center did not follow FDA guidelines when administering the medication. As a result, Holly died from a severe infection brought on by an incomplete abortion . . .

After extensive research, Patterson claimed that it was not only the medication that killed her, but also what he believes to be its improper application, as directed by the Planned Parenthood center that Holly visited. And according to Patterson, this practice is dangerously common. In his research, he claims to have uncovered other previously unreported deaths linked to the pill.

Los Angeles (Bixby)

Lopez

	"Clinic Doctor Faulted in Abortion Death" By Steve Hymon, Staff Writer, *Los Angeles Times,* June 25th, 2003.

A 25-year-old woman bled to death last year after a Planned Parenthood clinic in East Los Angeles neglected to follow established medical procedures during an abortion, according to a report by the state Department of Health Services. The report also found that the clinic failed to report Diana Lopez's death within 24 hours, as required, and that a doctor working there did not follow clinic policies that would have excluded the woman as a candidate for the procedure. . .

Among the most serious allegations in the state report is that Maltzer violated clinic procedure because he went forward with the abortion even though Lopez's hemoglobin levels were below the clinic's standards. Low hemoglobin levels often lead to increased bleeding. The report also states that Maltzer did not follow the clinic's standards in waiting until Lopez was sufficiently dilated before the procedure.

The clinic did not report Lopez's death to the state until a week later, even though such notification is supposed to be done within 24 hours, the report said.

The report also found that Planned Parenthood's patient records lacked basic information on Lopez's care and condition . . .

Illinois

Chicago

Reaves

The autopsy report and court settlement document for $2 million can be found at:

www.problemsatplannedparenthood.org/illinois-chicago

Excerpt from Autopsy:

OPINION: The cause of death of this 24-year-old, Black female . . . is due to hemorrhage resulting from cervical dilation and evacuation due to an intrauterine pregnancy.

	"Family Seeks Answers After Woman's Death Following Abortion" Published *Channel 2 CBS Chicago,* July 21st, 2012

Excerpt:

Tonya Reaves, 24, died late Friday night from a hemorrhage, with a cervical dilation and evacuation, as well as an intrauterine pregnancy as contributing causes, according to the medical examiner's office.

She died after she'd had an abortion at Planned Parenthood at 18 S. Michigan Av, according to the medical examiner's office.

Her death was ruled an accident, but the Reaves family wants to know more, especially Tonya's twin sister Toni.

"We were born the same day. She was my other half," Toni said.

Toni Reaves said the family is trying to get through this.

"It happened so fast. She was just fine one day and then the next day she was gone. We're just trying to figure out what happened. what happened," she said.

Toni Reaves said her sister was engaged to be married and had one son - Alvin - who just had his first birthday.

Massachusetts

Worcester

Name Unknown

Incident Report
"Anonymous Woman Death Incident Report"
See problemsatplannedparenthood.org/massachusetts/ for link to report

Excerpt/Screenshot:

4

Date Reported: 12/31/2008
Date Submitted: 06/22/2011

Date of Incident: 12/ /2008
Time of Incident: :

FACILITY INFORMATION

Facility: Planned Parenthood Leag Ma Cnt Ma C (4163)
470 Pleasant Street
Worcester, MA 01609

ID: 4163
Type: Clinic Form
Facility Reported: No

INCIDENT NARRATIVE

Complainant's Letter: The Complainant is reporting that allegedly a Client/Patient of this Clinic died because of medical practice by an identified Doctor. The Complainant also alleges that this Clinic has not complied with the Law and is asking DPH to investigate this Clinic's actions and death of the Client/Patient of this Clinic, who allegedly died by an The Complainant has enclosed and attached a copy of the Death Certificate of the Client/Patient.

Michigan

Kalamazoo

Erwin-Sheppard

	"Dead Woman's Ultrasound Showed Clot, Problems after Abortion, Records Show" by Rosemary Parker*, Mlive Michigan,* April 13th, 2017

Excerpt:

Cree Erwin-Sheppard went to the emergency department at Bronson Battle Creek Hospital the evening of July 2, 2016 vomiting and in extreme pain . . . By July 4, she was dead . . .

According to the medical record of that emergency visit, shared by her brother Thursday, April 13 at a protest of her death, "the patient's symptoms and work-up results were consistent with an incomplete miscarriage and pelvic pain."

An ultrasound showed "the presence of a clot and/or retained products of conception," the record shows.

She was given morphine for pain, another prescription to calm her vomiting, and prescriptions for more pain pills and anti-nausea medication to be filled after discharge.

Erwin-Sheppard was sent home with her mother with instructions to follow up with a doctor or Planned Parenthood after the holiday weekend. She died before that was possible.

A copy of an unfilled prescription for pain medication obtained from Erwin-Sheppard's mother bears the signature of a doctor at Planned Parenthood in Kalamazoo, but the clinic, citing privacy laws, would not confirm the woman had ever been a patient there . . .

[T]he redacted death certificate received shows Erwin-Sheppard was pronounced dead shortly before 1 a.m. July 4 of "complications of intrauterine pregnancy, including (with lay translations in parentheses) pulmonary emboli (blood clots in the lungs) related to uterine vein thrombosis (blood clot in the uterus) and uterine perforation status post early vacuum aspiration (abortion) and intrauterine contraceptive device placement (placement of an IUD)."

Nevada

Las Vegas Hospital Sued After Woman Dies from “Septic Abortion” in 2022.
by Gregg Haas, *KLAS Channel 8 News*, September 22, 2023

Excerpt:

Alyona Dixon of Pahrump died Sept. 28, 2022, six days after she sought help at a Planned Parenthood clinic for a medically induced abortion. Four days later, she went to St. Rose Dominican’s Blue Diamond campus with “sharp” lower abdominal pain that started the previous day, according to details provided in the lawsuit.

After a few tests — notably without a pelvic exam or a consultation with a gynecologist — Dixon was discharged on the afternoon of Sept. 26, the lawsuit says. She was told to follow up with a gynecologist, and go to the emergency room right away if her symptoms worsened or changed.

Dixon went to the emergency room at Desert View Hospital in Pahrump after 11 p.m. on Sept. 27, and also reported vaginal bleeding. A doctor there described her condition: “abdominal pain, vomiting and diarrhea, severe dehydration, acute renal failure, leukocytosis, sepsis, lactic acidosis, hypokalemia, sinus tachycardia, metabolic acidoses, pulseless electrical activity, respiratory failure.” After treating Dixon and seeing her symptoms improve, the doctor got approval to transfer her to a Clark County hospital.

But her condition quickly deteriorated an hour later and she remained at Desert View, according to an attorney.

As her heart rate elevated to 150 and she had trouble breathing, doctors worked to intubate and sedate her. She vomited during the process and her heart stopped. Attempts to resuscitate her failed, and she was declared dead at 5:32 a.m. on Sept. 28. The Clark County Coroner’s Office gave her cause of death as “complications from septic abortion.” . . .

When she went to Planned Parenthood, Dixon was “determined to be an appropriate candidate for elective termination of pregnancy with mifepristone followed 24-48 hours later by misoprostol intravaginally,” according to Atallah’s letter. But it does not say she was given the treatment. “She was appropriately counseled about the risks of the medical abortion and was discharged home,” the letter says.

New York

Manhattan

Owens

The full Complaint can be found at:

www.problemsatplannedparenthood.org/new-york-city

Excerpt:

16. In April, 2009, 17-year-old . . . was a senior in high school in excellent health, looking forward to graduating and attending college in the fall.

17. On the morning of April 11, 2009 [she] went to Defendant Planned Parenthood for a scheduled termination of pregnancy . . .

18. . . . Defendant [doctor] . . . noted in his operative report that the procedure was "uneventful" and that there were no complications.

19. According to Defendant Planned Parenthood's own records, however, [she] was observed experiencing labored breathing immediately after the procedure ended at 9:20 A.M. Her oxygen saturation levels were also reported to have dropped.

20. Despite [her] apparent deteriorating condition, the Doctor and Nurse Anesthetist and Planned Parenthood failed to properly monitor her or to administer the proper treatment and failed to make timely contact with EMS until 9:43 A.M. In fact, due to the delay in recognizing and treating [her] condition, [she] was not transported to St. Vincent's Medical Center . . . until 10:05 A.M.

21. Although St. Vincent's was able to stabilize [her], Defendants' delay and the resultant hypoxia caused [her] to suffer severe irreversible injury. She required a respirator thereafter and was unable to leave the hospital. [She] died at St. Vincent's five months later on September 8, 2009.

Part 2:
Non-Medical Problems

Chapter 5

Cases cited here are in three categories:

- Non-reporting of Cases of Abuse of Minors (which allowed the abuse to continue)
- Lack of Policy to Report Abuse
- Sexual Harassment (of patients, or of staff by the doctor)

United States

	"The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities" by Laura J. Lederer and Christopher A. Wetzel *Annals of Health Law* - Vol 23 Issue 1, 2014, Page 77

BEAZLEY INSTITUTE

FOR HEALTH LAW AND POLICY

Despite their abusive situations, most survivors did receive medical treatment at some point during their trafficking. Of those who answered the questions about their contact with healthcare (N=98), 87.8% had contact with a healthcare provider while they were being trafficked. By far the most frequently reported treatment site was a hospital/emergency room, with 63.3% being treated at such a facility. Survivors also had significant contact with clinical treatment facilities, most commonly Planned Parenthood clinics, which more than a quarter of survivors (29.6%) visited. More than half (57.1%) of respondents had received treatment at some type of clinic (urgent care, women's health, neighborhood, or Planned Parenthood).

Table 6. Victim Contact with Health Care Provider

Treatment Source	**% Reporting** (N=98)
Any contact with healthcare	*87.8%*
Any type of clinic	*57.1%*
Hospital/ER	63.3%
Planned Parenthood	29.6%
Regular doctor	22.5%
Urgent care clinic	21.4%
Women's health clinic	19.4%
Neighborhood clinic	19.4%
On-site doctor	5.1%
Other[39]	13.3%

Excerpt:

Case study, pp. 76-77:

During the time I was on the street, I went to hospitals, urgent care clinics, women's health clinics, and private doctors. No one ever asked me anything anytime I ever went to a clinic . . . I was on birth control during the 10 years I was on the streets – mostly Depo-Provera shots which I got at Planned Parenthood and other neighborhood clinics. I also got the morning-after pill from them. I was young and so I had to have a waiver signed in order to get these – one of the doctors (A private doctor I think) signed this waiver when my uncle took me to see him.

-- Lauren, survivor

Alabama

Birmingham

The court document, Consent Agreement for Downgrade of License to Probation, 2010, can be found at

www.problemsatplannedparenthood.org/alabama

Excerpt:

1. In order to settle this dispute, Planned Parenthood voluntarily accepts a downgrade of its license to operate the Center to probational status . . .
5. . . . Planned Parenthood agrees that it shall:
a) . . . the Center's policies shall also require reasonable measures to verify that any individual signing the consent for an abortion involving a minor patient is actually a parent or legal guardian capable of giving such consent . . .
b) Develop and implement written policies and procedures to ensure full compliance with the mandatory reporting requirements of the Alabama Child Abuse Reporting Act . . .
f) . . . maintain an infection surveillance logbook in the manner required [by Alabama law] . . .

Arizona

Phoenix

Doe

	Planned Parenthood found negligent in reporting girl's abortion by Beth DeFalco, *Arizona Daily Sun*, Dec 26, 2002

Excerpt:

A judge found Planned Parenthood negligent for failing to report to Child Protective Services an abortion performed on a 13-year-old girl in foster care . . . The girl's case dates back to 1998, when the teen went for an abortion at a Planned Parenthood clinic accompanied by her 23-year-old foster brother, with whom she was having a sexual relationship.

Planned Parenthood didn't notify authorities until the girl returned six months later for a second abortion, court records show.

Lawsuits filed on behalf of the teen contend the Glendale girl was subjected to continued molestation and sexual exploitation because the abortion provider and others didn't notify police or CPS of her first abortion on Nov. 10, 1998. The girl's attorney also argues that Planned Parenthood's gross negligence led to her second abortion six months later.

Maricopa County Superior Court Judge Cathy Holt ruled last month that the abortion provider was negligent in failing to notify authorities when the girl first came in.

California

Affiliate: Mar Monte

	A former employee sues Planned Parenthood, alleging retaliation for speaking up about harassment by Mary Duan, *Monterey County Weekly*, October 31, 2019

Excerpt:

The woman once responsible for cultivating donors and bringing in major cash contributions to the largest Planned Parenthood affiliate in the country has sued her former employer, alleging the organization mishandled a sexual harassment and assault claim brought by another employee, then fired her when she repeatedly expressed her concerns about it.

Elizabeth Winchester says she was fired in late 2018 from the job she held at Planned Parenthood Mar Monte after she twice complained to her supervisor and CEO Stacy Cross about how they were handling the harassment and assault complaint. In her suit, filed Oct. 10 in Monterey County Superior Court, Winchester says Planned Parenthood issued her a “final written warning for alleged professional misconduct” after her second complaint, which she made on Oct. 24, 2018, and that her subsequent firing was in retaliation.

Fresno

	‘Nowhere is safe.’ Women accuse ex-Planned Parenthood offical of sexual harassment. by Mackenzie Mays, *Fresno Bee*, October 12, 2018

Excerpt:

For years, Pedro Elias was the face of Fresno’s branch of Planned Parenthood. At news conferences and events, as the director of public affairs, he stood out in a sea of women advocating for reproductive rights: A muscular man often wearing a bright pink Planned Parenthood T-shirt.

But when his employment ended in September after working for the organization since 2000, his colleagues came forward to surmise why.

"He flaunted his advocacy for women while sexually harassing and assaulting multiple women for years," said Sarah Hutchinson, policy director for ACT for Women and Girls in Visalia.

Los Angeles

Case 1: Lenihan

	Diocese Pays $1.2 Million In Sex Lawsuit by Greg Winter, *The New York Times,* April 2, 2002

Excerpt:

A California woman who accused a priest of sexually abusing her and then paying for an abortion when she was a teenager will receive $1.2 million to settle her suit against the Roman Catholic Church, the two sides said yesterday.

The woman . . . said that in 1978, when she was 14, the priest . . . began a pattern of abuse that lasted throughout much of her adolescence. The contact began with fondling and kissing, she said, culminating in her pregnancy at 16.

"When I told him about the pregnancy, he told me that I had to get an abortion . . .Father John drove me to his bank, withdrew the money and gave it to me to pay for the abortion. Father John did not go with me to Planned Parenthood. I remember how alone and scared I felt."

Note

Though the successful lawsuit was against the church, Planned Parenthood also allowed the abuse to continue since they apparently never reported; if they had, the abuse would have stopped earlier.

Case 2: Ramirez

The Appeals Court Document. Response of prosecutors when defendant appealed aspects of the verdict, can be found at:

www.problemsatplannedparenthood.org/california-los-angeles

Excerpt:

. . . The undisputed evidence in this case established beyond a reasonable doubt that defendant continued to have sexual intercourse with his 13-year-old Daughter . . .
BACKGROUND

. . . In July of 2010, K.R. [the daughter] had an abortion at a Planned Parenthood clinic. She did not tell the clinic staff that defendant had impregnated her, but instead made up a story about having a boyfriend her own age. The doctor told her not to have sex for three weeks after her abortion. Although she relayed this information to defendant, he resumed having sex with her a "couple of days later."

By December of 2010, defendant had again impregnated K.R. and she returned to Planned Parenthood for another abortion. The physician who performed the second abortion testified that K.R. was approximately six weeks pregnant. After the abortion, he implanted an intrauterine device to prevent additional pregnancies.

K.R. testified that she did not have sex with anyone other than defendant during the time she lived with him.

Defendant was arrested on or before March 16, 2011, after J.R.[K.R.'s older sister] reported his conduct toward her to the police.

Sacramento

Martin-Santana

	Medical assistant at Planned Parenthood faces sex charge by Michelle Schultz, NBC KCRA Channel 3, December 4, 2013

	Parenthood Employee Accused Of Sexual Battery Against Patient December 4, CBS Sacramento Channel 13, 2013

San Francisco

Cross

The court document, People of California v. Cross, Appeal Opinion, can be found at:

www.problemsatplannedparenthood.org/california-s-to-z

Excerpt:

Evidence at Trial

. . . K. testified that when she was 13 years old . . . appellant had her lie on his bed, took off her clothes, and had sexual intercourse with her. Appellant told K. not to tell her mother what had happened or K. would be sent to a foster home.

Over the next several weeks, appellant had sexual intercourse with K. once or twice a week when her mother was away at work. K. testified that occasionally she would pretend she was asleep, but that sometimes appellant would then get angry and punish her by taking away her cell phone or telling her that she could not see her friends. Appellant put his penis in her mouth three or four times. K. said that she did not tell her mother about any of this because she believed she would be taken away from her mother if she did.

K. told appellant that she had missed her menstrual period and he took her to Planned Parenthood where a pregnancy test confirmed that she was pregnant. K. testified that appellant told her that she "had to get an abortion."

On December 17, 2002, appellant drove K. to San Francisco General Hospital for an abortion . . . K. testified that she did not tell her mother about the abortion because she "didn't want her to have the police take me away or want her to hate me." . . .

One night, appellant's wife (Wife) caught appellant naked in bed with K. K.'s mother picked up the phone to call the police but appellant and K. convinced her that they were not having sex. About two weeks later, Wife found some old papers related to the abortion. When she confronted K., K. admitted that she had been pregnant and had had an abortion. Wife testified that K. said that appellant had told her not to tell because she would be taken away from her mother.

Colorado

Denver

Smith

Court documents can be found at:

www.problemsatplannedparenthood.org/colorado

Excerpt from Amended Complaint:

SUMMARY OF THE CASE

1. This case seeks economic and non-economic damages arising from the Defendants' multiple failures to inquire about how a thirteen-year-old girl became pregnant, or what her relationship was to the adult man who brought her to Defendants for an abortion, despite numerous opportunities to speak to the girl alone; their failures to report known or suspected sexual abuse despite numerous indications that the man had sexually abused the girl; and administration of a long-term and undetectable form of birth control to the girl despite her fear of needles, all of which enabled the man to continue his years of sexual abuse of the girl without discovery or consequence.

Note:
In July of 2012, the adult man was charged with two counts of felony sexual abuse and, in January of 2013, he was sentenced to 28 years in prison.

Connecticut

Enfield

Lanza

	Man imprisoned for sex with underage Enfield girls by Zachary F. Vasile, Journal Inquirer, January 10, 2018

A man convicted of having a three-way sexual encounter with two underage Enfield girls, one 14 and the other 12, when he was 18 was sentenced Tuesday in Hartford Superior Court on Tuesday to spend two years in prison . . .

Affidavits supporting Lanza's arrest claim that the older girl told Enfield police that she had a relationship with Lanza starting in February 2014 and continuing on until April 2015. She also said that he got her pregnant in November 2014, while she was still 14, and claimed that Lanza forced her to have an abortion.

The affidavits do not explain how the girl alleged that Lanza forced her to have the abortion, but did include her statement that Lanza made an appointment for her at Planned Parenthood in Enfield and that Lanza's father had driven her to the clinic.

West Hartford

This article is no longer on the web.	3 sentenced for holding teenage girl prisoner by Jenna N. Carlesso, *Journal Inquirer,* July 12, 2008 (updated March 6, 2013)

In the year she was held captive by a West Hartford dog trainer . . Cramer endured the same treatment as the animals in his business: She was groomed and abused by someone she trusted, a prosecutor said Friday.

But when police found the girl locked away deep inside Adam Gault's home last summer, they did more than rescue an abducted teenager.

They broke Gault's cycle of preying on impressionable young females . . .

During the months Gault held Cramer captive, police say, he repeatedly abused and raped her, resulting in her pregnancy. He later ordered Cray to bring the girl to a Planned Parenthood clinic where, under a false identity, Cramer had an abortion.

Delaware

Nurse's Testimony

See the full letter from Nurse Mitchell at:

www.problemsatplannedparenthood.org/delaware

Excerpt:

Sexual Harassment: I have noted Dr. Liveright inappropriately look up and down patients as well as staff members in a sexual kind of way. He actually stands back with a grin and slowly directs his eyes up and down a patient's body.

Massachusetts

All the media coverage of Dr. Roger Ian Hardy indicates he is a fertility doctor and worked at various fertility clinics, primarily in Boston, but there is also documentation that he also worked at Planned Parenthood centers. The Boston Globe has quite a bit of coverage of this case; this article offers the best summary:

	Why didn't anyone stop Doctor Hardy? In college and in his medical practice, Roger Hardy left a long trail of women who said he abused them. by Liz Kowalczyk and Patricia Wen, *The Boston Globe*, December 6, 2015

Michigan

Ann Arbor

Borokwa

The complaint details allegations of sexual harassment, sex discrimination, and retaliation. Full court documents, including settlement order, can be found at:

www.problemsatplannedparenthood.org/michigan

New York

Rochester

Commissioner's Order Number 7906 can be found at:

www.problemsatplannedparenthood.org/new-york

Lizardi

Excerpt:

(a) On or about February 2, 1983, while the Respondent was employed at Planned Parenthood of Rochester . . . the Respondent preformed a gynecological examination on Patient A . . . During this examination, the Respondent without medical purpose:
(i) Stimulated Patient A's clitoris;
(ii) Questioned Patient A about her sexual ac tivities; and
(iii) Told Patient A that she had a pretty face and beautiful eyes, while touching Patient A's breasts.

(b) In or about July 1983, while the Respondent was employed at Planned Parenthood, the Respondent performed a gynecological examination on Patient B. During this examination, the Respondent without medical purpose:
(i) Suggested to Patient B that she call him anytime she wanted;
(ii) The Respondent subsequently telephoned Patient B at her home in or about August, 1983 and had sexual relations with her; and
(iii) Patient B returned to Planned Parenthood in or about September 1983, because of a vaginal infection. During Patient B's examination, the Respondent spoke to Patient B in an obscene, threatening and disparaging manner.

Ohio

Case 1: Roe

The court document can be found at:

www.problemsatplannedparenthood.org/ohio

Excerpt from the Facts and Procedural History

Pages 3-4:

6} In the fall of 2003, when Jane was 13 and in the eighth grade, she began a sexual relationship with her 21-year-old soccer coach, John Haller. In March 2004, Jane discovered that she was pregnant and told Haller. Haller convinced Jane to have an abortion. He called Planned Parenthood and attempted to schedule an abortion for her. Planned Parenthood told Haller that he could not schedule the procedure and that Jane would have to make the appointment. After this conversation, Haller told Jane to schedule it, and he also instructed her that if asked to provide a parent's telephone number, she should give Planned Parenthood his cell phone number in lieu of her father's phone number.

7} Jane called Planned Parenthood and told an employee that she was 14 years old and that her parents could not accompany her. She asked whether her "stepbrother" could come with her. The employee asked whether Jane's parents knew about her pregnancy. Jane lied and told the employee that one or both of her parents knew. In fact, neither knew. Jane gave the employee her father's correct name and address, but

she lied twice more, telling the employee that her father did not have a home phone number and then giving Haller's cell phone number as her father's phone number.

8} Planned Parenthood scheduled the abortion for March 30, 2004. The employee told Jane that someone would have to stop at Planned Parenthood to pick up an information packet but that Jane did not have to personally retrieve the packet. Sometime before the procedure, Haller picked up the information packet for Jane . . .

13} Haller ended the relationship soon afterward. After the breakup, a teacher overheard an argument between Jane and Haller's sister, a classmate of Jane's, about Haller and his relationship with Jane, including references to Jane's sexual relationship with Haller. The teacher reported the suspected sexual abuse to the police. After a criminal investigation, Haller was convicted of seven counts of sexual battery. A criminal investigation was also conducted into Planned Parenthood's culpability, but the Hamilton County prosecutor did not prosecute Planned Parenthood for any statutory violation.

Case 2: Fairbanks

Fairbanks v. Planned Parenthood Southwest Ohio Region et al.
Filed May 7, 2007. Settled September, 2012.

In her own words, a letter from Plaintiff Fairbanks, January 2, 2012:

She's out there. Somewhere. A girl just like me. Somewhere there's a young innocent girl—barely a teenager. And right now, she's suffering from the horrors of sexual abuse at the hands of an adult as I did. Somewhere "that girl" is getting raped. Like I was. Impregnated. Like I was.

And she may be taken to a Planned Parenthood abortion center. Like I was. "That girl" may actually be *telling* Planned Parenthood that she's being abused. Probably by her boyfriend. In my case, I was abused by my own father . . .

I was thirteen years old when my father started to abuse me, and my father continued to abuse me for almost two years after he took me to Planned Parenthood to have an abortion.

Pennsylvania

Philadelphia (Locust Street)

The inspection document can be found at:

www.problemsatplannedparenthood.org/pennsylvania

No policy for sex abuse reporting

Excerpt:

Based on feedback from surveyor during the August 29, 2013 survey, the surgical center manager reviewed Pennsylvania State law and PPSP protocols specific to mandatory reporting at center staff meeting on September 17, 2013. PPSP Chief Operating Officer and Manager of Center Quality with legal consultation will revise current protocol to include language on when to ascertain if the child had sexual intercourse with an individual who was four or more years older than the child. The revised protocol will be in place by January 15, 2014 . . .

Lack of documentation when reporting child sexual abuse as revealed in survey 8/29/13 was reviewed at the 9/17/13 center staff meeting. Detailed instructions on required documentation was reviewed.

Texas

Houston

The full Consent Decree of the Equal Employment Opportunity Commission can be found at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Castro

No incidents are detailed, and Planned Parenthood denies culpability, but settled the case for a $40,000 payment plus agreeing to training and policy changes to prevent sexual harassment of employees.

Washington State

Savanah

The full Savannah Appeals Decision can be found at:

www.problemsatplannedparenthood.org/

Excerpt:

(*Savanah is the defendant; his daughter is only identified as R*)

After Savanah's daughter, R, disclosed that she had been sexually abused, the State charged Savanah with four domestic violence sex offenses. At trial, R testified at length to the abuse. R stated that Savanah raped her for the first time when she was 14 years old. She recounted sexual abuse that continued for the next seven years.

R testified that she became pregnant three times, when she was 14, 16, and 17 years old. In each case, Savanah took her to Planned Parenthood for an abortion. Records from Planned Parenthood confirmed that Savanah took R to the clinics for the procedures.

Bellingham

Gonzalez-Jose

This article is no longer on web.	*The Bellingham Herald*, May 16, 2014

An Everson man who impregnated a preteen girl and forced her to have an abortion must serve a six-year prison sentence, then leave the country.

Luis Gonzalez-Jose, 31, raped the girl at a home in rural Whatcom County while her mother was in the shower, according to charging documents filed in Whatcom County Superior Court.

He brought the girl to a Planned Parenthood clinic in August 2012. She told staff members that her 14-year-old boyfriend impregnated her, but she couldn't give the boy's name or address.

Six weeks after the abortion, the girl told a detective how she had really become pregnant.

Chapter 6

United States

	Planned Parenthood Has a History of Trying to Beat Back Labor Unions. Erin Heger, *ReWire News Group*, July 19, 2018

Excerpt:

Out of 56 Planned Parenthood affiliates across the United States, only five are unionized, according to the Planned Parenthood Federation of America (PPFA): Planned Parenthood of New York City, Planned Parenthood Metro D.C., Planned Parenthood of Central and Western New York, Planned Parenthood of the Great Northwest and Hawaiian Islands, and Planned Parenthood Columbia Willamette.

	Planned Parenthood Is Accused of Mistreating Pregnant Employees by Natalie Kitroeff and Jessica Silver-Greenberg, *The New York Times,* December 20, 2018

Arkansas, Kansas, Missouri, Oklahoma

	Planned Parenthood Great Plains Cuts Staff Amid Complaints Of 'Chaos And Toxicity' KCUR (Kansas City Public Radio), by Dan Margolies, July 9, 2020.

Colorado, New Mexico, Nevada

	Planned Parenthood's Union Busting Could Have a Chilling Effect for Workers Everywhere, by Rebecca Burns, *In These Times*, June 25, 2018
	'Frustrating,' 'Confusing': Planned Parenthood Workers Grapple With Organization's Union Fight: A fight in Colorado over Planned Parenthood unionization has some wondering why the reproductive health-care champion would stand in the way, by Erin Heger, *ReWire News Group*, June 14, 2018
	Planned Parenthood is Asking Donald Trump's Labor Board for Help Busting its Colorado Union: If Planned Parenthood is to prevail, it could be a setback for similar workers across the country by Aida Chávez, *The Intercept*, May 23, 2018

Iowa, Massachusetts, Minnesota, Nebraska, South Dakota

	Planned Parenthood workers in five states announce intent to unionize by Max Nesterak, *Iowa Capital Dispatch*, May 26, 2022
	These screenshots are from a video from More Perfect Union: Building Power for Working People. It's about union organizing for Planned Parenthood. The video advocates the mission of Planned Parenthood and argues that its efforts will help make the mission more effective.

Retention is not very high
just because the wages are low,

our schedules are very large,

and our support is pretty minimal
from the company itself.

and people that have been with the company for
ten or more years are leaving after,

you know, not having their voices
heard for a very long amount of time.

Maine, New Hampshire, Vermont

	New Planned Parenthood Union Takes to the Street Arnie Alpert, The New Hampshire Center for Public Interest Journalism, August 29, 2021

Excerpt:

The issue in contention is wages, which union members say are too low at the low end of the agency's pay scale and rising too slowly for long-term employees.

New When Katelin Smith, a Holderness resident, arrived, she quickly grabbed a blank placard and marker to make a sign that said, "I cannot afford the care I provide." Others made signs reading, "Better Pay, Help Us Stay," and "A Livable Wage is All the Rage."

Arizona

The court document, Complaint of Plaintiff Rodriguez, can be found at:

www.problemsatplannedparenthood.org/arizona

	Planned Parenthood Whistleblower Awarded $3M, Ending Wrongful Termination Case by Brianna Smith, Legal Reader, August 23, 2019

Excerpt:

According to the suit, a former Planned Parenthood director, Mayra Rodriguez, sued the organization for wrongful termination in 2017 after 17 years of service. Towards the end of her career, she began reporting that the "organization was endangering the health and safety of the women visiting their facility." Soon after, she was fired.

Though Rodriguez's suit did not list specific damages she hoped to win, a two-week trial and a three-hour deliberation resulted in an Arizona jury siding with her. In the end, the jury unanimously awarded her $3 million for acting as a whistleblower . . .

What were the accusations included in the suit, though? What were the issues Rodriguez reported that led to her wrongful termination? For starters, the

lawsuit included several “accusations against Planned Parenthood that demonstrated its lack of medical care, concern for patients, and unethical practices.” Her suit added that “Planned Parenthood fired her after she observed its many violations of state law and ethics guidelines, and after it fabricated a bunk claim that she had narcotics in her desk.”

Additionally, “a couple of months before her termination, Rodriguez made several complaints against doctors and questioned business practices,” according to the suit. On top of that, she began to notice a pattern of a “Planned Parenthood official performing abortions on patients who then experienced significant complications, including bleeding and cramps.” The suit further stated, “Ms. Rodriguez was concerned about the substantial health, welfare, and safety risks to these patients, as well as the substantial risk to the health, safety, and welfare of the inevitable future of PPA patients.”

As if those claims weren’t enough, the suit also alleged that a handful of medical assistants often “complained about working with the same doctor during abortions and that the doctor had been requiring the assistants to sign an affidavit stating the abortion procedure was performed properly before they even did the procedure.” The suit stated:

“*The medical assistants believed the attestations were premature, wrong, and illegal because the abortion surgery had not yet been performed and they were concerned about the quality and thoroughness of the procedures.”*

On one occasion, a medical assistant even had to track down the doctor “after an ultrasound revealed the doctor had placed an IUD in a patient before an abortion was fully completed.” On another occasion, one of the facility’s managers allegedly “did not report that a minor with an adult partner was seeking an abortion, a blatant violation of state law meant to protect potential victims of statutory rape.”

Eventually, Rodriguez voiced her concerns to her supervisor, even though she did not feel comfortable doing so because her supervisor and doctor in question were friends.

Soon after the jury’s decision, Tim Casey, Rodriguez’s attorney, met with reporters and said “the jury found Rodriguez was doing her job by reporting her concerns . . . It vindicated what she found and it ought to help our community be safer.”

California

Chula Vista

Murray

Filed June 10, 2014.
Settled: June 30, 2015

The Court Documenst, Complaint and Actions, can be found at:

www.problemsatplannedparenthood.org/california-a-f

Excerpts:

14. In or about the late summer or early fall of 2012, [Plaintiff complained to Mendoza [Defendant] that the Chula Vista clinic was in violation of the law because Mendoza was directing non-licensed Clinicians to access the locked medication cabinet and dispense medication to patients . . .

15. [Defendant] began to retaliate against Plaintiff . . .

25. Despite Planned Parenthood's mission as alleged, the Chula Vista clinic manager (a non-licensed staff member), authorized the injection of birth control to a minor patient, against the will of the minor and absent an order by a licensed medical provider. This unauthorized administration of medication without a license was, and is, a violation of California law . . .

35. On or about March 30, 2013, [Plaintiff] was terminated. In its termination letter, Planned Parenthood indicated that [Plaintiff] was terminated because her performance was "below expectations."

36. A short time later, Planned Parenthood reported to the California Employment Development Department that Plaintiff was terminated because after she reported the March 8th incident, Plaintiff "refused to move on."

37. Plaintiff is informed and believes, and thereon alleges that she was terminated because she reported her supervisor's unlawful administration of medication without a license.

Colorado

Aurora

Post from June 18, 2018, next page:

Pro-Choice. Pro-Patient. Pro-Union.

PPRM Bargaining Team

PPRM Bargaining Team
@PPRMBargaining

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PPRM Bargaining Team
June 18 ·

REGARDING THE EVENTS LAST WEDNESDAY.
This past Wednesday evening a colleague and I, in our role as members of the SEIU, Local 105 collective bargaining team and proud representatives of the clinical staff from 14 PPRM centers who voted and won the right to unionize in December, 2017; planned to attend the annual fund-raising event held by Planned Parenthood of the Rocky Mountains to raise support for their advocacy & political arm, Planned Parenthood Votes Colorado. Our purpose was to ask donors to specify their money be used only for patient care activities and legislation that supports those activities, not for paying the high-price law firm hired by PPRM last summer to stop the formation of our collective bargaining unit. The event was being held at a public venue with certain areas reserved exclusively for ticketed attendees.

The tickets we purchased for the event were revoked with our money refunded immediately before start time of the event. I had arrived at the venue before learning I no longer had a ticket. My colleague was called off and never arrived; three SEIU staff members had also arrived to learn of ticket cancellations.

Suspecting our tickets had been revoked to prevent us from attending and speaking to donors, I decided to go up to the event to see if there was a public space outside the private event where I could talk to donors as they went in. I was accompanied in this by one union staff member. Upstairs, we were able to determine there was no public space, and while figuring this out, I was seen and recognized by event organizers and attendees. Becoming nervous, I suggested we return to the main floor.

Stepping back into the first floor public space, I saw uniformed and armed Aurora police officers beginning to approach us. Not wanting a confrontation, I walked away from them. Although I had seen three Aurora police cars when I first met up with union staff, I honestly did not believe they were there to keep us out of the event. However, it quickly became obvious that was exactly their purpose, because they began to follow us as we walked away into the mall.

Recognizing we were not going to be able to accomplish anything useful, the four of us decided to split up and make our way casually, visiting some shops along the way, back to the main entrance. The police officers also split up to follow each of us, thus leaving the event itself indicating they were not there for event security.

My car was parked on the opposite side of the building from the union staff so I had to walk back through the mall to reach it. As I walked past the event, the police officers saw me and watched me all the way to the exit. Getting into my car, I became very afraid that I was going to be followed and pulled over by one of the police units. I called my husband and recounted the entire story and he was also concerned and told me to stay on the phone with him and not to leave the parking lot for a while. I think I sat there in my car about 15 minutes, then finally got up the courage to leave through a small exit in the back of the parking lot, feeling very shaken. My impression was the police were there to ensure I and my SEIU companions left the event and did not return. That impression was fully supported later when I learned from one of our union organizers, that he had doubled back to the event and watched all of the police cars leave as soon as we were not on the premises.

Florida

Miami

	Planned Parenthood Is Accused of Mistreating Pregnant Employees by Natalie Kitroeff and Jessica Silver-Greenberg, *The New York Times*, Dec. 20, 2018

In Miami, one current and two former employees said that women at a Planned Parenthood office were scared to tell managers they were pregnant. One of them said that, in conversations with supervisors, colleagues would often volunteer that they were not planning on having children or were gay or single.

"It was looked down upon for you to get pregnant," said Carolina Delgado, who worked in the Miami office until 2012. "I don't think that any supervisor had to literally say it for us to feel it."

Dupont

The court document, Complaint of Plaintiff Dupont, can be found at:

www.problemsatplannedparenthood.org/florida

Case 8:18-cv-00333-JSM-CPT Document 1 Filed February 8, 2018

Excerpt:

FACTUAL ALLEGATIONS

7. Defendant hired Ms. Dupont to serve as its Controller on or about August 1, 2016, at an annual salary of $87,500 per year; Defendant increased her salary to $97,500 . . .
8. On June 14, 2017, Ms. Dupont suffered serious physical injuries in an automobile accident.
9. The severity of Ms. Dupont's injuries required her to seek continuing treatment, and to take time away from work to heal and continue her recovery for same.
10. Specifically, Ms. Dupont suffered from bulging and herniated disks, one of which pressed against Ms. Dupont's sciatic nerve, causing her immense pain, and inability, to walk, sit, sleep, or stand, for any prolonged period.
11. Based on the severity of these impairments and her continuing treatment for same, Ms. Dupont's medical condition was a serious health condition as defined by the FMLA.

12. Ms. Dupont, accordingly, notified Defendant, that she intended to take FMLA time away from work to treat her injuries and heal, as advised by her doctors and medical team . . .
17. Defendant, without valid cause, reason, or explanation, denied same.
18. Instead, Defendant notified Plaintiff that it was, instead, terminating her employment, and then ultimately replaced her with a temporary employee that Defendant had intended for Plaintiff to train.
19. This too not only constitutes FMLA interference, but also actionable FMLA retaliation.
20. Had Defendant complied with the FMLA, which it didn't, it would have known that an employee cannot be penalized for absences that are FMLA protected.

Illinois

Chicago

The court documents, Complaint and Response, can be found at:

www.problemsatplannedparenthood.org/florida

Harkless

Headings for Allegations of Complaint:

B. [Planned Parenthood of Illinois] PPIL's Failure to Notify Plaintiff of Her Rights Under the [Family and Medical Leave Act] After Notification of Her Serious Health Conditions

C. Violations of the Confidentiality of Plaintiff's Medical Records by Defendants PPIL and Tao

D. Defendant Tao's Inappropriate and Discriminatory Comments and Behavior Toward Plaintiff and Other PPIL Employees

E. PPIL Had Notice of Defendant Tao's Discriminatory Behavior and Comments

F. Plaintiff's Termination and PPIL's Changing Reasons Given to Support It

G. Defendant PPIL's Intimidation of a Witness Who Did Not Support Its Defense for Terminating Plaintiff

Indiana

Indianapolis

Brown

The full Complaint can be found at:

www.problemsatplannedparenthood.org/indiana

Excerpt:

10. The Defendant hired Ms. Brown on or about September 30, 2013.
11. Throughout her employment with Defendant, Ms. Brown met or exceeded Defendant's legitimate expectations of performance.
12. On or about June 13, 2016, Ms. Brown provided the Defendant with notice of her disability, which was a diagnosis of cervical cancer.
13. Due to her disability Ms. Brown had to undergo frequent doctor visits.
14. Ms. Brown had to have a biopsy performed every three (3) months.
15. The Defendant made it difficult for Ms. Brown to take a day off every three (3) months in order to have her biopsy performed.
16. The Defendant told Ms. Brown to schedule her biopsies for Monday's as that would make it easier for her to have the day off.
17. The Defendant continued to make it difficult for Ms. Brown to get the day off for her biopsy, even when scheduled on Mondays.
18. Ms. Brown informed the Defendant that she was going to have surgery due to her disability.
19. The day before her surgery, Ms. Brown called off of work due to pain and bleeding associated with her disability.
20. The Defendant texted Ms. Brown stating "you will not take off without a valid reason."
21. Ms. Brown had never called into work prior to this date.
22. When Ms. Brown returned to work after surgery she had restrictions.
23. It was difficult for Ms. Brown to sit due to her disability.
24. If and when Ms. Brown did sit she needed a comfortable chair.
25. On or about March 20, 2017, approximately two (2) weeks after Ms. Brown's surgery there was a staff meeting.
26. When Ms. Brown arrived for the staff meeting there were no open chairs.
27. Ms. Brown felt that standing was better for her anyway due to her disability.
28. Ms. Brown would have had to violate her restrictions in order to carry a chair into the room.
29. Ms. Brown opted to stand due to these complications caused by her disability.

30. Ms. Brown was terminated on or about March 20, 2017 for standing during the staff meeting.

31. Ms. Brown was told that her standing during the staff meeting was "intimidating" and "disrespectful" towards the Vice President . . .

34. The Defendant intentionally and willfully discriminated against Ms. Brown due to her disability.

COUNT I: DISCRIMINATION ON THE BASIS OF A DISABILITY

COUNT II: FAMILY MEDICAL LEAVE ACT

Note: The EEOC dismissed the complaint because it was "unable to conclude that information obtained established violations of the statutes. This does not certify that the respondent is in compliance with the statutes."

Kansas

Overland Park

The full Complaint can be found at:

www.problemsatplannedparenthood.org/kansas

Blunt

Excerpts:

1. This action arises under Title I of the Americans with Disabilities Act . . .
2. Plaintiff Blunt, an African American female, who also has a disability as defined under the ADA . . .
7. Plaintiff Blunt has exhausted all her administrative remedies, having received a Notice of Right to Sue from the Equal Employment Opportunity Commission . . .
11. When Plaintiff began her job with PPKM, she was instructed to catch up on approximately three years of backlogged accounts receivable. She was told to fix serious accounting problems and reconcile numbers which could not be substantiated.
12. Plaintiff was not provided substantial, meaningful, or sufficient training to do her job. . .
17. The stress caused by the workload and pressure to provide an immediate solution to the backlog began to affect Plaintiff's Bipolar Disorder, resulting in her promptly visiting her doctor to adjust her medication.
18. Plaintiff's doctor and therapist advised her to speak with her supervisor(s) to request help with her workload . . .

22. The following day, on October 1, 2015, PPKM terminated Plaintiff and refused to provide her with a reason.
23. At all times, Plaintiff was meeting the legitimate job expectations of Defendant, and, upon information and belief, had not been disciplined, written up, or warned about her performance.

Count I: Failure to Provide a Reasonable Accommodation in Violation of the ADA . . .
Count II: Disability Discrimination/Disparate Treatment in Violation of the ADA
Count III: Retaliation in Violation of the ADA
Count IV: Discrimination in Violation of 42 U.S.C. § 1981

New York

See also the Open Letter from Employees in Chapter 7, Racism.

	A Worker Uprising at Planned Parenthood Melissa Gira Grant, *The New Republic*, June 18, 2020

Excerpt:

As Covid-19 hit New York, staff at a number of Planned Parenthood health centers found themselves facing two crises at once: keeping health services going and keeping their jobs. As some health centers closed temporarily and shifted to telehealth services, staff also saw their hours cut or positions furloughed. To hear workers describe it, this was not entirely unforeseen. For more than a year, they had pressed management to improve conditions for staff, particularly for Black workers, and for the patients they care for. Some on staff have now decided to take their demands public, "inspired and emboldened by national movements led by Black people holding organizations and institutions accountable and working to dismantle systems of oppression and white supremacy."

	How an Ousted CEO Built a Culture of 'Covert Racism' and Fear at Planned Parenthood's Largest Affiliate by Esther Wang, *Jezebel*, June 24, 2020

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Excerpt:
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[W]hen Laura McQuade, the former head of Planned Parenthood Great Plains, became the new CEO of Planned Parenthood of New York City, Adams quickly felt a shift in the organization's culture. Part of it stemmed from a promotion that required Adams to move from the Brooklyn clinic, which was largely staffed by people of color, to the organization's administrative office—a "largely white space," as she put it. "People of color are at the frontlines, but as you go through the ranks, it becomes whitewashed," Adams said . . .

But Adams pinned most of the blame on McQuade, who instituted what she described as a toxic "mean girl" culture and an environment suffused with "covert racism."

On Tuesday, the board of Planned Parenthood Greater New York announced that they had "parted ways" with McQuade . . . Staff concerns against McQuade included accusations of racism and bullying, as well as charges that she had instituted a revenue-driven, assembly-line approach to PPGNY clinics–one that put patients, and in particular Black and other patients of color, at potential risk.

	As Contract Fight Drags On, Planned Parenthood Workers Say Enough is Enough 1199 Magazine (SEIU union), February 22, 2021

Excerpt:

Frustrated 1199ers at four New York City clinics run by Planned Parenthood of Greater New York (PPGNY) held informational pickets Jan. 7 to demand that management stop dragging their feet and settle a fair contract now.

Workers voted unanimously in August 2019 to join 1199SEIU. And PPGNY's stalling around a contract settlement commenced almost immediately. More recently, PPGNY telegraphed its intransigence by hiring an HR director straight from a union-busting law firm. And as New York City's second wave of COVID-19 hit its peak, PPGNY proposed givebacks on workers' healthcare coverage.

	Planned Parenthood In Crisis: Workers Demand Union! by Joe Maniscalco, LaborPress.org, July 23, 2014

Excerpt:

No less than eight elected officials from both the New York State Legislature and United States Congress are calling upon Karen Nelson, CEO, Planned Parenthood of

Western and Central New York, to honor workers' overwhelming decision to have CWA Local 1168 represent them in future contract negotiations.

So, far, however, Planned Parenthood's leadership is refusing – insisting that an official election must be held.

Roughly 70 percent of the Planned Parenthood workers in Central New York already signed union authorization cards in June. The 60-plus employees working in five Planned Parenthood centers around Central New York, say that management has busted down workers to part-time status, while also stripping them of their job titles, and telling them they must reapply for their positions . . .

Fed up, as many as 10 Planned Parent workers have reportedly left the organization in the last three weeks. Those remaining, say that patients are often double booked, requiring staffers to stay on the job long past regular business hours. At the same time, workers say that post-merger management has callously altered worker schedules with no regard for employees' familial obligations.

DeSouza

The full Complaint and the Appels Court Decision in favor of plaintiff can be found at:

www.problemsatplannedparenthood.org/new-york

Excerpt:

The Complaint plausibly alleges facts showing "but-for" causation. There is a close temporal connection of approximately one month between Plaintiff's protected activity and the adverse employment action. Plaintiff sent emails complaining of microaggressions against Jewish people to Walker on October 20 and 28, 2020. Her employment was terminated on November 30, 2020.

	Fired Jewish Planned Parenthood Worker Can Sue for Retaliation by Patrick Dorrian, *Bloomberg Law*, June 8, 2022

White Plains

	Planned Parenthood Is Accused of Mistreating Pregnant Employees by Natalie Kitroeffand Jessica Silver-Greenberg, *The New York Times*, December 20, 2018

Tracy Webber, the former director of clinical services in White Plains, sued the organization for pregnancy discrimination in 2009, saying she had been fired four weeks after giving birth. Planned Parenthood settled for undisclosed terms. . .

As a medical assistant at Planned Parenthood, Ta'Lisa Hairston urged pregnant women to take rest breaks at work, stay hydrated and, please, eat regular meals.

Then she got pregnant and couldn't follow her own advice.

Last winter, Ms. Hairston told the human-resources department for Planned Parenthood's clinic in White Plains, N.Y., that her high blood pressure was threatening her pregnancy. She sent the department multiple notes from her nurse recommending that she take frequent breaks.

Managers ignored the notes. They rarely gave her time to rest or to take a lunch break, Ms. Hairston said.

"I had to hold back tears talking to pregnant women, telling them to take care of their pregnancies when I couldn't take care of mine," she said . . .

When Ms. Hairston asked for regular breaks, including 30 minutes for lunch, her supervisors brushed her off. Ms. Hairston said she sent multiple notes from her nurse at Full Circle Women's Health to the regional office's human resources department, stating that the extra breaks were medically necessary. No one responded, and nothing changed, according to Ms. Hairston and the former human resources manager.

Ms. Hairston's hands and feet swelled; the clinic's plastic gloves no longer fit. Her blood pressure got so high that her doctor put her on bed rest when she was seven months pregnant.

She returned to work on strict orders to not work more than six hours a day and to take regular breaks. One day in March, she worked a much longer shift. She soon became so sick that her doctor told her to go back on bed rest. A few days later, on March 23, she went to the hospital. Doctors performed an emergency C-section. She was 34 weeks pregnant.

When she had been on maternity leave for eight of the 12 weeks guaranteed by the Family and Medical Leave Act, Planned Parenthood's human resources department called her multiple times and urged her to return to work early, Ms. Hairston said. She emailed the department and said she felt "discriminated against." She resigned in June.

"I didn't get into the medical field to be treated like this," she said.

North Carolina

	Planned Parenthood Has a History of Trying to Beat Back Labor Unions Erin Heger, ReWire News Group, July 19, 2018

Excerpt:

Jessica Rubio, a nurse practitioner in North Carolina, said she experienced pushback 14 years ago when she and her colleagues tried to unionize at Planned Parenthood of Central North Carolina (PPCNC).

"Management became very nasty," Rubio told *Rewire.News*. "There was a lot of blatant intimidation."

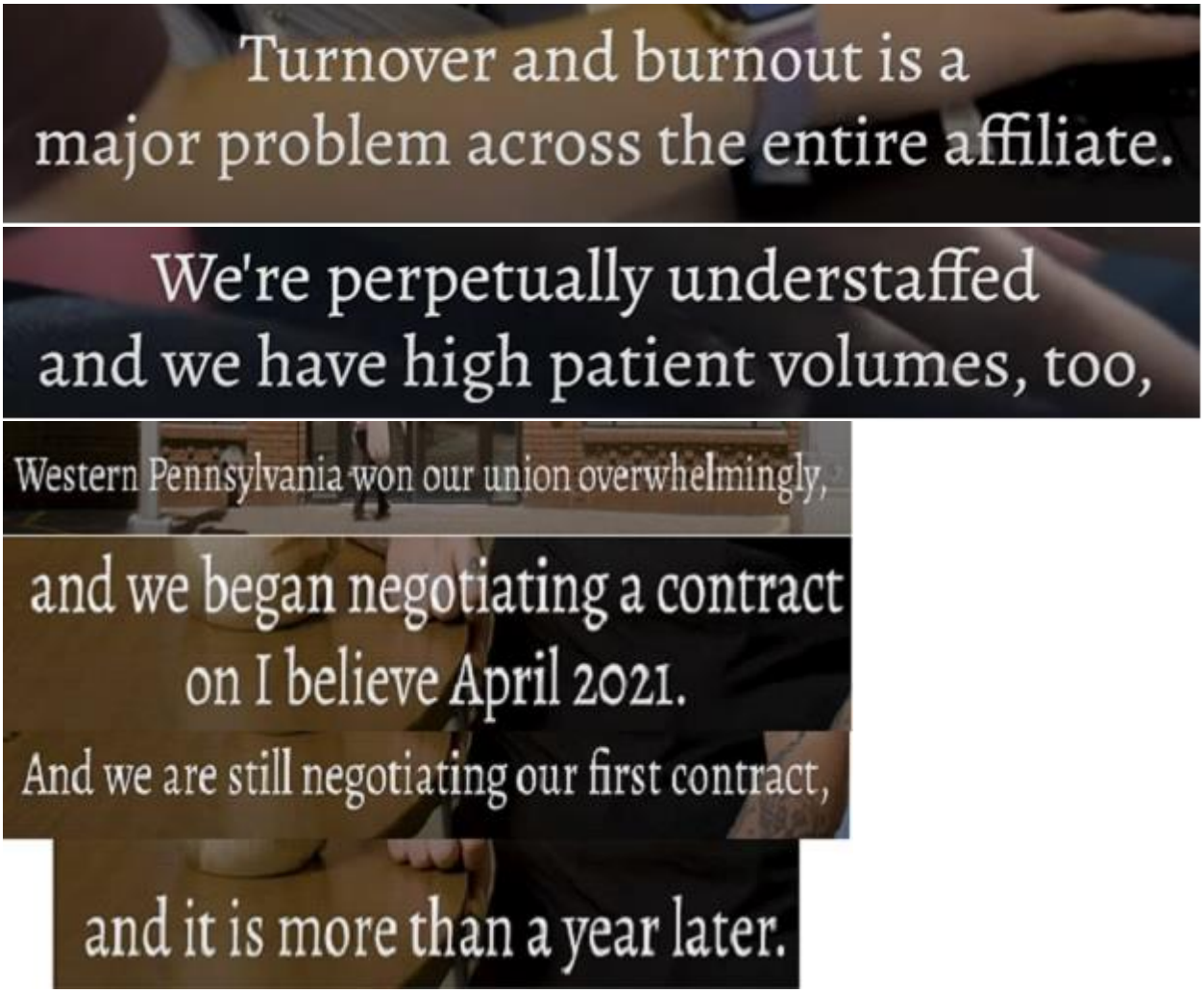
After seeing discrepancies in promotions and wanting to address concerns over pay and benefits, Rubio and several of her colleagues at PPCNC began organizing a union in 2004. They received immediate pushback, Rubio said, with management scheduling mandatory anti-union meetings as well as pulling workers aside in the hallway and telling them a union would hurt Planned Parenthood . . .

Rubio and her colleagues eventually won their union election, but management dragged out contract negotiations for so long that many workers ended up leaving and the bargaining unit dissolved . . .

Rubio's experience trying to unionize at PPCNC ended with her vowing to never again work for a Planned Parenthood affiliate. "I'm passionate about reproductive health, but I'm sad to say that's no longer funneled toward Planned Parenthood," Rubio said. "I am so disillusioned by the exploitation of those working and sacrificing for the cause."

Pennsylvania

	These screenshots (next page) are from a video from More Perfect Union: Building Power for Working People. It's about union organizing for Planned Parenthood. The video advocates the mission of Planned Parenthood and argues that its efforts will help make the mission more effective. These screenshots are specific to Pennsylvania:



Tennessee

Nashville

	Former Planned Parenthood Employees Allege Mismanagement. by Steven Hale, *The Nashville Scene,* December 18, 2018

The *Scene* spoke to four staffers from the facility, some of whom have lost their jobs as a result of the closure, and all describe a turbulent six months leading up to the announcement. Some learned of the news by email, while others found out when they checked a work schedule and noticed their name no longer appeared on it.

The staffers also say a number of patients with upcoming appointments received a terse text message informing them that the appointment had been canceled . . . The blunt, cold delivery of the news is in line with what they describe as a number of recent policy changes at the clinic that they perceived as being designed to prioritize money over patients . . .

As for “quality improvement,” some former staff members say they believe that’s a euphemism for replacing employees who pushed back on troublesome policy changes with new ones who will be more compliant.

Texas

Austin

	Planned Parenthood employees laid off, claim it’s retaliation for voicing concerns by Alex Caprariello, KXAN, Austin NBC news affiliate, April 10, 2020

More than a dozen workers at Planned Parenthood clinics across Austin are now without a job. They say they believe it’s direct retaliation for both voicing complaints to the CEO and their ongoing efforts to unionize within the past year.

Planned Parenthood management confirmed it made staff cuts, but it says it’s a business decision it had to make because of COVID-19.

Austin and Fort Worth

Dalton

The full Complaint can be found at:

www.problemsatplannedparenthood.org/texas-austin

Excerpt:

IV. FACTUAL BACKGROUND

5. Mrs. Dalton is a licensed registered nurse with a statutory duty to her patients in accordance with the Texas Occupations Code.

6. Mrs. Dalton worked for Planned Parenthood . . . from June 6, 2016 until February 28, 2017 when she was suddenly discharged from her employment in retaliation for tirelessly advocating for patients by making repeated protected reports about safety concerns that exposed the patients and the public to risk of injury and even death . . .

7. Mrs. Dalton made the first report about safety concerns when she was sent for training at the Fort Worth Planned Parenthood ASC location [Southwest Center] in June of 2016. Specifically, Mrs. Dalton recognized that a patient who was . . . in the recovery room was increasingly pale, shaky, sweating and made the nursing diagnosis of potential for shock with decreasing blood pressure and oxygen saturation. The nurse in the recovery room was simply recording vital signs without critically thinking at all about the data assimilated with the patient condition. Mrs. Dalton had to rescue the patient by providing emergency fluid resuscitation and was "written up" for doing so. At that point she was told that she could only "observe" and not do patient care. She asked to terminate her "observation period" and returned to Austin where she immediately reported the situation in Fort Worth as well as the absence of fluids and orders to administer them in the recovery area. Her concern fell on deaf ears .

9. The Ben White Clinic [South Austin Center] was chronically understaffed with nurses who kept quitting yet overflowing with patients. As a result, the "flow" of patients was increased to dangerous levels and corners were cut to save time. When Mrs. Dalton reported the dangerous conditions, the Charge Nurse . . . stated "I was hired to improve patient flow. I am not a nurse manager."

10. For example, patient operative records were "pre-populated" . . . with information even before they went to the operating room in violation of minimum nursing standards . . .

11. Patients were allowed to wear long sleeved garments that would not accommodate being "rolled up" to expose the deltoid as an injection site . . . Mrs. Dalton . . . complained about this practice to her Charge Nurse . . . after such an event caused . . . the tight garment to slip and encounter the needles . . .

12. . . . Mrs. Dalton raised valid concerns about liter bags being used and single dose medications NOT MULTI DOSE and posing yet another safety hazard and consulted with the clinic pharmacist . . .

20. Mrs. Dalton alleges and will prove that Defendants engaged in needless dangerous practices that exposed patients to risk of injury an death and she tried to prevent such risk from recurring and Defendants response to her protected reports was to cause termination of Mrs. Dalton's employment .

Fort Worth

The full Complaint can be found at:

Belmonte

www.problemsatplannedparenthood.org/texas-dallas-fort-worth

Excerpt:

III. FACTS

12. On August 8, 2017, Decedent, . . . Belmonte, was at her place of employment at a location of Defendant Planned Parenthood, where she experienced intermittent chest pain. When paramedics and employees of MedStar first arrived at Planned Parenthood, Decedent stated that her chest pain was not severe. However, her condition quickly deteriorated, and she went into cardiac arrest immediately after being loaded onto a stretcher.
13. Plaintiff . . . arrived on the scene at Planned Parenthood and attempted to enter the room where his wife, the Decedent, was being treated by Defendant MedStar first responders. Even though the employees of Defendant Planned Parenthood knew Plaintiff . . . was the spouse of Decedent, the employees prohibited him from entering the room where Decedent was being treated . . .
14. After treating Decedent for an unreasonably extended period of time at Planned Parenthood, Defendant MedStar's first responders transported Decedent to Harris Methodist Hospital Southwest in Fort Worth, Texas where she subsequently passed away within an hour of arrival.
15. Several weeks following the passing of Decedent, Plaintiff . . . received a letter from UT Southwester informing him the Decedent was involuntarily placed in a federal study that consisted of conducting alternative cardiac arrest treatments on qualified patients. However, Decedent never gave consent to be placed into this study as she was unconscious . . . nor did the first responders receive consent from her husband . . . because he was never consulted . . .
18. Defendants . . . negligently caused and negligently permitted nonconsensual and inadequate treatment to be administered . . . and negligently failed to warn Decedent or Plaintiff . . . of the risks associated with the treatment; prevented Plaintiff] . . from refusing the treatment being studied; and prevented [Plaintiff] . . . from taking [the Decedent, his wife, to the nearby hospital emergency room, despite the fact that Defendants . . . should have known of the risks involved with the treatment and that there was a likelihood Decedent could be injured or pass away, which is exactly what happened to Decedent.

Washington State

Yakima

Sharp

	Former Planned Parenthood employee wins lawsuit in Benton County *The News Tribune*, Tacoma News, July 11, 2012

Excerpt:

After an eight-year battle, a former Planned Parenthood employee won a lawsuit in Benton County alleging that the organization fired her because of a disability . . .

Her neck and back pain sometimes made Sharp unable to perform all of her job functions, and her lawsuit alleged that Planned Parenthood fired Sharp rather than provide reasonable accommodations. . .

[Her attorney] said Sharp had never received a negative performance evaluation or reprimand, and that the organization's human resources department performed no independent investigation . . .

The case finally came to trial in June, and a jury on June 27 awarded more than $136,000 to Sharp after finding that she was fired because of her disability.

Chapter 7

United States

Planned Parenthood itself offers detailed information on its own racist history:

	The History & Impact of Planned Parenthood

Further examples from recent years:

	Employees Are Calling Out Major Reproductive Rights Organizations for Racism and Hypocrisy by Ema O'Connor, *Buzzfeed*, August 21, 2020
	Dozens of Black Employees Said They Faced Racism at Planned Parenthood, An Internal Audit Found by Ema O'Connor, *Buzzfeed,* October 9, 2020
	Ex-Planned Parenthood Employee Says Racist, Toxic Culture Sent Her to the ER by Emily Shugerman and Brianna Sacks, *The Daily Beast,* October 19, 2022
	Former Planned Parenthood Employee Sues Organization, Alleging Racism And Mistreatment Of Black Women KSRO Talk Radio, October 20, 2022

Excerpt:

(NEW YORK) — A former Planned Parenthood employee is suing the organization, alleging the reproductive healthcare nonprofit retaliated against her and ultimately fired her for speaking out against its treatment of Black women.

Plaintiff Nicole Moore, the former director for multicultural engagement at Planned Parenthood based at the national headquarters in Manhattan, New York, claims in the complaint filed on Wednesday that Planned Parenthood has perpetuated a culture of racism where Black women within the organization are discriminated against through unequal work distribution and opportunities for promotions.

“[Planned Parenthood] has blatantly ignored reports by dozens of its Black employees of systemic unequal hiring and promotion, more work for lower pay, overt hostility, and trafficking in stereotypes by leadership,” according to a copy of the complaint obtained by ABC News.

Moore, who says she served in the role from Jan. 13, 2020, through Nov. 2, 2021, also claims that “Black-centered campaigns were deprioritized and under-resourced.”

Moore

A full copy of the October 19, 2022 Complaint can be found at:

www.problemsatplannedparenthood.org/united-states

Excerpt:

When [Plaintiff] politely spoke up about the inequitable distribution of work, she was falsely accused of being negative, angry, difficult to work with, and chastised for her "tone" - complaints that had no basis in reality but comported with well-trafficked stereotypes about Black women. Planned Parenthood executives then proceeded to thwart Moore's ideas, sabotage her projects, and subject her to unfounded disciplinary measures that were clearly intended to silence her complaints. The barrage of mistreatment caused Moore to suffer a panic attack so severe that she spent a day in the hospital. After complaining to HR that the disciplinary measures appeared to be retaliation for her complaints of racial inequality at the organization, she was summarily fired.

California

Los Angeles

Jones

A full copy of the Complaint can be found at:

www.problemsatplannedparenthood.org/california-los-angeles

Excerpts:

8 . . . Plaintiff was the first African American male employee to ever be hired in his particular department by PPLA, and was the first such minority to hold his specific position . .

12. Among other things, as alleged below, Plaintiff refused to engage in PPLA promotional practices that were intended to deceive the African American community in South Los Angeles . . . Plaintiff, an African American, was not comfortable being forced to misrepresent facts to other similarly situated persons.

13. During this same time period, PPLA was also engaged in other activities having a deleterious effect on African American persons, including Plaintiff's fellow employee, one Nick Nkwuda, an African immigrant. Specifically, in or around January of 2004, Mr. Nkwuda was referred to as a "nigger." PPLA's management did nothing to punish the management employee who used such degrading language toward an employee similarly situated to Plaintiff in terms of minority status . . .

14, In fact, throughout 2003 and most of 2004, PPLA had created and allowed the continuation of an environment that was hostile toward African American and other minority employees, especially male employees. A female accounting supervisor referred to male employees in position of authority and officers of the company as "dickheads," and other derogatory terms, constantly defaming and engaging in confrontational behavior which was known throughout and brought to the attention of

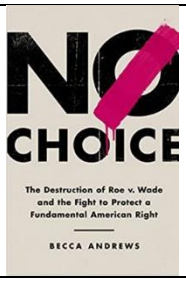
Human Resources and the interim and permanent CEO and President of PPLA. These terms were most often uttered by the female executive management of PPLA.

15, At the time of Plaintiff's employment, PPLA's white, female management staff also caused openly discriminatory comments and representations to be made that would have made a reasonable person feel uncomfortable . . .

16. The various circumstances described above created an environment that was racist and sexist in tone, policy and practice. These practices have not been abated by PPLA and continue to cause harm to individuals employed by PPLA. PPLA is the subject of multiple verified complaints having been filed with the California Department of Fair Employment and Housing within the last six months.

Indiana

Indianapolis

	*No Choice: The Destruction of Roe v. Wade and the Fight to Protect a Fundamental American Right* by Becca Andrews (New York: Public Affairs, 2022)

Book Excerpt:

Nowhere was the survival mode mentality more evident than in the unchecked behavior of the [doctor] at the clinic, a graying white man in his 50s . . .

She suspected that he was harder on patients who did not speak English, and she fought for privileges as the only Spanish speaker on staff to accompany Latinx patients into the procedure room so she could answer their questions and advocate for them if necessary.

New York

General Open Letter: Save PPGNY

	Current and former staffers of Planned Parenthood of Greater New York June 18, 2020

Excerpt:

Racism and Weaponizing of the Work of Diversity, Equity and Inclusion Against Staff

Planned Parenthood was founded by a racist, white woman. That is a part of history that cannot be changed . . . After years of complaints from staff about issues of systemic racism, pay inequity, and lack of upward mobility for Black staff, highly-paid consultants were brought in three separate times to assess the situation. Each time, employees of color were brutally honest about their experiences, but nothing changed . . .

When diversity and equity are weaponized to make changes that are harmful to staff it diminishes the value of these very important areas of change. We know that Planned Parenthood has a history and a present steeped in white supremacy and we, the staff, are motivated to do the difficult work needed to improve.

Decimation of Institutional Knowledge Due to Unprecedented Rates of Staff Turnover

McQuade's time at PPGNY has been defined by constant staff departures. Under her leadership, 23 members of senior staff have quit or been forced out. Many of these colleagues had 10-20+ years of experience with our affiliate. Others were people hired by McQuade directly to newly created positions who left mere months into their roles. This high amount of turnover has had a destabilizing effect on the organization. The loss of institutional knowledge is so profound as to be detrimental to every aspect of the organization.

. .

	Supplemental Open Letter: On Equity

June 18, 2020

We write this — as a group of both current and former BIPOC (Black, Indigenous, People of Color) employees of Planned Parenthood of Greater New York — to expand on the issues of racism and anti-Blackness in our workplace mentioned in our general open letter to the PPGNY Board . . .

PPGNY, under the leadership of CEO Laura McQuade, has effectively gaslit and silenced their marginalized staff thus creating a toxic work environment. While we stand together as people of color, we also stand firm in our commitment to acknowledge that anti-Blackness is a critical and specific fulcrum of white supremacy.

The PPGNY Senior Leadership team, despite the visual appearance of diversity, has repeatedly weaponized the language of diversity, equity, and inclusion. Rather than using their true definitions, senior leaders and upper management have used these terms to manipulate and silence those with differing opinions and perspectives. They have leveraged identity politics by putting Black and other people of color in positions of leadership who actively participate in harming Black staff and other staff members of color below them.

At this point, PPGNY's attempts to present itself as a diverse workplace have been carefully orchestrated and superficial at best. PPGNY repeatedly tokenizes their Chief Equity and Learning Officer, a Woman of Color who is not of African descent, as the "voice" for BIPOC staff. The decision to hire a non-Black person in this role exemplifies the ways in which white-led organizations use non-Black people as a buffer to actually confront and uproot anti-Blackness within organizations . . .

The class tensions are made clearer when the BIPOC leadership were also complicit in the decisions to furlough/terminate 28% of staff. This included the closing of health centers in the Bronx and Queens, as those areas were being devastated by COVID-19. Additionally furloughed staff, many of which are BIPOC women, remain unclear when they will be called back to work and left with no official information regarding when their health insurance will be terminated.

With multiple attempts by the BIPOC staff to bring these concerns to our supervisors, we continue to be invalidated and marginalized. White and non-Black employees are still given more pay and more advancement opportunities than their Black colleagues. Blanket statements are used to overshadow our grievances, while only exacerbating the problem. Black staff are further disheartened when our white and non-Black colleagues use their privilege to amplify our concerns, and find they, too, are challenged and manipulated into silence.

Mitchell

The full Complaint from March 7, 2023 can be found at

www.problemsatplannedparenthood.org/new-york-city

Excerpt:

. . . the reality is that Planned Parenthood continues to be run by people who are openly hostile to racial minorities, the disabled, older workers and those who complain about discriminatory practices.
Proof of this reality lies in the lawsuit filed by . . . Moore*, who on October 19, 2022 . . . alleged that Planned Parenthood continued to discriminate against African American employees . . .

Now , [defendant], the Chief Operational Officer and highest ranking African American male in Planned Parenthood of Greater New York's history, is filing this lawsuit alleging that he too has been victimized by race, gender, age and disability in violation of Federal State, and New York City laws. This lawsuit is meant to shine a light on the discriminatory and retaliatory employment practices that permeate the organization and bring justice to Mr. Mitchell for the unrelenting discriminatory practices he had and continues to endure.

* Moore's case is listed above in this chapter under United States.

Pennsylvania

Open Letter: Save PPPA

	On November 24, 2020, employees of Planned Parenthood released an open letter alleging racism and poor management of severe budget cuts. It was signed by the entire staff. The letter demanded the resignation of Executive Directo. She resigned on December 1, 2020.

	Planned Parenthood's Pennsylvania Chapter Director Resigns After Racism Claims by Emily Shugerman, *The Daily Beast*, December 2, 2020.

Huffmeyer

The full Race Discrimination Complaint can be found at

www.problemsatplannedparenthood.org/texas-houston-stafford

Excerpt:

18. At the end of August 2017, PPGC assigned a new supervisor to oversee Ms. Huffmeyer's performance . . . Following that appointment, Ms. Huffmeyer's workplace quickly turned into a living nightmare. Not only did [the new supervisor] persistently belittle Ms. Huffmeyer; she also resorted to treating her so badly that her work environment quickly became sufficiently hostile to start causing her health to deteriorate, all because of Ms. Huffmeyer's race and national origin. Among other health issues, Ms. Huffmeyer developed daily headaches and fever blisters . . .
22. Not only did [the supervisor] abuse Ms. Huffmeyer without cause as to her work; she also made inappropriate comments about her national origin. [She] once asked Ms.Huffmeyer how "close" she was to Ms. . . . Nguyen (the Director of the PPGC Center for Choice), just because both Ms. Huffmeyer and Ms. Nguyen were Vietnamese. Essentially, [she] assumed that two unrelated people would immediately form a clique in their workplace, just because they both happen to be of Vietnamese origin. Ms. Huffmeyer told Ms. [her] that she did not know Ms. Nguyen well at all. Ms. Farrell responded by stating that she did not trust Ms. Nguyen and that Ms. Huffmeyer should not trust her either. When Ms. Huffmeyer tried to reassure [her] that her only goal was to make sure she looked good, [she] dismissed her, saying, "I'm not sure about that! Birds of a feather . . .
29. Instead of seeing her working conditions improve, Ms. Huffmeyer was unceremoniously terminated, just over three months after the complaint was filed, without any respect for the ten years of impeccable service she delivered to the Company.

Chapter 8

United States

	You scheduled an abortion. Planned Parenthood's website could tell Facebook. The organization left marketing trackers running on its scheduling pages by Tatum Hunter, *The Washington Post*, June 29, 2022

California

Chico

The health department documents from 2012 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- A clinic employee looked up the private medical records of a patient without authorization. The patient was the ex-girlfriend of the man the employee was dating. The employee wanted to know details about the patient's sexual health and history for personal reasons. She later stated that she wanted to know if the patient had an STD. The staff member who reported the violation said that the employee in question had the file open at her desk and was reading it "like a magazine."

Chula Vista

The health department documents from 2013 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- Clinic staff spoke openly and loudly about the reason a patient came to the clinic in a manner that allowed other patients to overhear, which is a breach of confidentiality.
- Two patients with the same first name came to the clinic on the same day. One patient was mistakenly given the other patient's receipt, which had confidential information including fees and services given as well as the patient's address on it.

Coachella

The health department documents from 2014 can be found at:
www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- The clinic sent a notification of a positive chlamydia test to the wrong patient. The letter was mailed to one patient but was intended for another. One patient's address was written on the outside of the envelope, but the letter inside was addressed to a different patient. The letter contained the patient's name, personal details, and information about the STD. This was a breach of confidentiality.

El Cajon

The health department documents from 2013 and 2014 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- On three different occasions, patients were given or sent home with medication intended for another patient. The medications were labeled with the other patients' names and health information. This is a privacy violation and a risk of a patient mistakenly taking the wrong medicine.

Escondido

The health department documents from 2013 and 2014 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- A patient was given three medications that were intended for a different patient, posing a health risk for the patient.
- A patient was emailed another patient's personal medical information, including test results, medical history, diagnosis, and medications.

Fresno

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

- Staff put the wrong patient's label on a patient chart. Therefore, another patient saw that patient's personal information, including her name and date of birth.

Gilroy

The health department document from 2014 can be found at:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

- A patient had a relative working at the clinic. She told a staff member that she did not want this relative to know about her visit. However, the staff member went against the patient's wishes and told the relative not only about the visit, but also personal health information, including the confidential results of the patient's test.

Moreno Valley

The health department documents from 2014 and 2015 can be found at:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

- Two patients were tested for STDs. Patient A was sent Patient B's results, and Patient B was sent Patient A's results. Included in the letters were the wrong patient's name, address, and documentation of a positive chlamydia test.

Orange

The health department documents from 2014 and 2015 can be found at:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

- A staff member who was related to the father of a patient's child (in other words, a relative of the patient's current or former boyfriend/partner) accessed the patient's chart on four separate occasions without authorization. The staff member also revealed the patient's private health information to others. When questioned, the staff member acknowledged that she looked up the records out of "curiosity."
- On multiple occasions, patients were handed urine specimen cups with other patients' names and dates of birth on them.
- A physician's assistant gave a patient another patient's prescription, allowing the patient to see the other patient's name and the medicine prescribed to her. The prescription also included the other patient's phone number, address, and date of birth.
- A staff member handed a patient the wrong paperwork, revealing to her another patient's name and date of birth.
- Three different times, staff handed a patient another patient's Family Pact ID card, revealing the other patient's name, date of birth, and ID number.
- A patient asked for her records, and the printout included the records of another patient. This breach of privacy was especially serious because, in addition to name, date of birth, address, phone number, and medical history, it revealed part of the other patient's social security number.
- A patient was given the wrong login information for the clinic's patient portal. This meant that she had full access to another patient's records.
- A staff member left a packet of papers with the personal information of multiple patients in the bathroom, where they were found and turned in by another patient. These papers contained names, phone numbers, addresses, and in one case, the social security number. Also revealed were income, date of last menstrual period, and family size of some patients. Any patient or staff in the clinic had access to this information while it was left unsecured and unattended.
- The medical records of one patient were faxed to a stranger rather than the intended party. A staff member entered the wrong fax number. This was a breach of privacy.
- Staff attempted to impede the investigation into the breach of privacy mentioned above concerning the patient portal. They refused to cooperate with investigators and would not grant them access to medical records as required by law.

Riverside

The health department documents from 2014 can be found at:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

- A staff member placed the wrong label on a health access program card, allowing a patient to see the name, date of birth, and the medical record number of another patient.
- Lab results for a patient were mailed to the wrong address.
- A male staff member accessed a female patient's records without permission to obtain her cell phone number. He wanted it for his own "personal use." The staff member then texted the patient and asked if he could continue to text her. The patient reported this breach of privacy and unwanted contact to the clinic.

San Bernardino

The health department documents from 2014, 2015, and 2015 can be found at:

www.problemsatplannedparenthood.org/california-s-to-z

Highlights:

- The clinic accidentally faxed a patient's personal information to the wrong fax number, (a breach of privacy). The information included the patient's date of birth, phone number, address, medical history, family medical history, past surgical history, weight, height, medications, sexual history, results of an HIV test, and drug use history. All this information was sent to a stranger.
- Clinic staff mistakenly mailed a patient's records to an "outside entity." The records included the patient's health history as well as their name, address, and date of birth.
- A staff member accessed the records of a patient with whom she was acquainted and looked up her medical history, looking at the records on four occasions. The staff member learned details of the patient's financial status, procedures, notes, medications, and treatments. The staff member was also accused of accessing records of three other patients but was not officially cited.
- A staff member compromised the privacy of 19 patients when she took a screenshot of the clinic schedule and texted it to her boyfriend. The schedule showed the names and phone numbers of the patients and the reasons they came to the clinic

San Diego

The health department document from 2014 can be found at:

Highlights:

- A patient was given a bottle of medication with another patient's name and information on it.

San Jose

The health department documents from 2014 can be found at:

www.problemsatplannedparenthood.org/california-san-diego

Highlights:

- A patient was given and took home a bag with the name and information of another patient on it.
- A patient received mail with another patient's information on it, including her name, date of birth, and address.

Seaside

The health department document from 2012 can be found at:

www.problemsatplannedparenthood.org/california-s-to-z

Highlights:

- A patient came in who was a family member of a clinic employee. The employee looked at and read the patient's medical records without authorization or medical purpose. She accessed her family member's records 17 times over the course of a day.

Watsonville

The health department document from 2016 can be found at:

www.problemsatplannedparenthood.org/california-s-to-z

Highlights:

- A patient's family member was given the medical information of another patient.

Delaware

See the full Letter from HHS/OCR responding to complaint at:

www.problemsatplannedparenthood.org/delaware

Excerpt:

On August 23, 2013, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), Region III received a complaint alleging Planned Parenthood of Delaware . . . has violated the Federal Standards for Privacy of Individually Identifiable Health Information . . . Specifically, the complainant alleged that Planned Parenthood of Delaware has no curtains or separations between patient treatment areas, permitting patients to hear other patients' protected health information.

Illinois

See the full Letter from HHS/OCR responding to complaint at:

www.problemsatplannedparenthood.org/illinois

Excerpt:

On October 9, 2013, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), Region III received your complaint alleging Planned Parenthood . . . has violated the Federal Standards for Privacy of Individually Identifiable Health Information . . . Specifically, you allege that, an employee of Planned Parenthood impermissibly disclosed your protected health information (PHI) to a third party. You stated that, on September 25, 2013, [redacted] left a comment under the public posts of your Facebook page pertaining to a procedure you had done at Planned Parenthood.

Iowa

Dubuque

	Planned Parenthood leaves records in Dubuque; info of 2,500 potentially exposed by Jeff Montgomery, *Telegraph Herald*, July 6, 2016

Excerpt:

About 2,500 patients of Planned Parenthood of the Heartland's now-closed Dubuque center recently were notified that their health records might have been among those left behind when the facility closed in April.

Public Relations Manager Rachel Lopez said hard copies of patient information were inadvertently left at the building at 3365 Hillcrest Road and that they might have been accessed by unauthorized parties following the center's closure and ensuing building sale. . .

The documents were found by the building's new owner May 6. Lopez said Planned Parenthood sent letters to all affected patients Friday, July 1 — nearly two months after the discovery . . .

Executive Director Kris Nauman said the documents were discovered during a May 6 final walk-through at the facility. Clarity Clinic closed on the building purchase later that day.

The medical information was located in a closet in "copy paper boxes" that were not sealed, she said.

See also:

	Patient records left at closed Dubuque Planned Parenthood center by the Associated Press, Des Moines Register, July 6, 2016

New York

Rome

The full letter from HHS/OCR responding to complaint can be found at:

Excerpt:

On October 6, 2011, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), Region III received your complaint alleging Planned Parenthood . . . has violated the Federal Standards for Privacy of Individually Identifiable Health Information . . . Specifically, you allege that in September 2011 [redacted], a workforce member of Planned Parenthood, located in Rome, New York, impermissibly disclosed your protected health information to your sister's friend.

Chapter 9

Indeed.com is a site that among other things provides a place for employees to give reviews of their employers. For Planned Parenthood, these reviews would appear under the specific centers the employees worked for.

We collected a set of hundreds of reviews revealing problems. Screenshots are under each PP center that has them on the website. We offer a sampling of some of the worst reviews.

For an accurate understanding of employees' experiences as a whole, those who choose to post reviews will be inadequate and a full survey or stratified random sample study would be needed. We're unaware of any such study.

CA Los Angeles Indeed 11

1.0

★☆☆☆☆

Run!

Operations Manager (Former Employee) - Los Angeles, CA - June 24, 2022

They need to clean house with a consultant agency. Planned parenthood has a culture like no other. The leadership is highly inexperienced, unprofessional, and makes up rules as they go. It's like nothing I've ever experienced before. They manipulate their staff, install fear, and take advantage. It was hard to watch and experience such a toxic culture from such a well-known organization. They have ridiculous workflows, unreasonable bench marks and the wait-times at the centers are awful. Not to mention the meetings about meetings are nonstop. They are all talk and no change. The turn over rate is outrageous as well but once you meet the VP's you will understand why. It's so sad.

✓ **Pros**

Interacting with patients and great services offered

✕ **Cons**

Horrible uneducated no experienced leadership

IA Urbandale Indeed 1

1.0

★☆☆☆☆

Awful

Clinic Assistant (Former Employee) - Urbandale, IA - November 10, 2020

Underpaid, racist, no room for growth, really negative work environment poor management m. Didn't match 401k no raises but regular review of performance. No rewards for going above and beyond. Awful work environment.

✓ **Pros**

Really liberal work place

✕ **Cons**

I will never work in a clinic again if it's anything like this

IL Chicago Indeed 1

1.0

★☆☆☆☆

Low wage, high volume , unsanitary conditions

Nurse Practitioner (Former Employee) - Chicago, IL - May 25, 2020

I took a pay cut of about 15k annual to work here because I believe in the mission. Job was an absolute nightmare. Most clinics are managed by people with no degrees or clinic background, they are people who have just worked there for decades and moved up. They train their own medical assistants and none that I met had any certification or any formal training out of the clinic. Meaning these are lay staff without a clue about clinical guidelines, evidenced based research, etc. But these "managers" will micro manage your clinical practice and even try to tell you how to write your prescriptions. The RHAs aka Medical assistants are the ones who run the show, and can do no wrong. there is a culture in the clinic that the clinical providers can be easily disposed of, but the RHA staff is here to stay. You must watch what you do and say at every second because the RHAs are trained to run to management and report everything (snitch). You will be made to feel that your licensure and education is worthless and the hierarchy in the clinic is in reverse, you will get no respect. These medical assistants don't even want to give injections, the clinicians must give them, the rooms are filthy, and its not uncommon to find yesterday's dried up bodily fluids on the exam tables and mayo stands because the rooms are not cleaned well in between patients. Yes, absolutely horrifying , I agree.
The benefits are pathetic, huge medical dedutable plans. You cannot use PTO if more than 2 people are on vacation in the whole state, yes, I said that, the whole STATE of Illinois. There is much much more, I could go on for another 3 paragraphs, but I will just sum it up. PLEASE RUN AS FAR AS YOU CAN FROM EMPLOYMENT HERE! They do not care about their employees, they only care about numbers and generating revenue. While I was there, good clinicians were terminated at the blink of an eye. If you are injured, disabled or sick, you will get terminated instead of being allowed to use your benefits.
I was in shock and horror working there.

✓ **Pros**
none

✖ **Cons**
poor benefits, low pay, micromanagement, unkempt dirty workplace

IN Merrillville Indeed 1

1.0 ★☆☆☆☆

Worst job experience of my life

Family Nurse Practitioner (FNP) (Former Employee) - Merrillville - January 27, 2020

If you like to be bullied and not valued for your skills, this is a great place to work. If you desire autonomy and desire to critically think, look pass them. NPs are undervalued and disrespected, which is even worse for NPS of color. Most unorganized company where you feel like you are the first hire in this longstanding company.

✓ **Pros**
Meet about 3 welcoming employees out of 100s.

✗ **Cons**
Fake, phony, not trustworthy, no indepence or voice allowed, hostile environment

MI Kalamazoo Indeed 1

2.0 ★★☆☆☆

Hostile/Toxic work environment

Clinician (Former Employee) - Kalamazoo, MI - April 24, 2018

High patient volume, with no concern on connecting with patients; treat and release.
Poor communication between staff and management
Discrimination and unequal staff treatment regardless of job performance.
High staff turnover.
Corruptive, manipulative office management.

✓ **Pros**
No weekends

✗ **Cons**
often no lunch break, discrimination, toxic staff work environment

MO Columbia Indeed 1

3.0

★★★☆☆

No people of color in management for the past 25 years.

Health Educator (Former Employee) - Columbia, MO - August 30, 2020

The mission is clear to provide access to reproductive health care for all. PPGP does that very well.
The management continuously overlooks internal BIPOC employees, and does not give 2nd interviews to exrernal job candidates of color either. This friction is felt when PPGP comes into collaborative relationships with other PP affiliates in the state, as well. It is also reflected in the volunteers and the board for PPGP.

✓ **Pros**
Working for a great, needed cause. Making a difference in the healthcare received by people;

✗ **Cons**
Non-supportive on BIPOC employees, Work life balance, Job stress are high because of the nature of the work., bosses take the credit for everything

OK Oklahoma City Indeed 2

1.0

★☆☆☆☆

Fraud

Clinic Assistant (Former Employee) - OKC, OK - April 14, 2017

Fraud fraud fraud and more insurance fraud. Half of the people that work at ppco are strung out. They dont give a hoot about employees just how to collect insurance money for services not done. If fact health center manager is a big pot head

✓ **Pros**
None

✗ **Cons**
Everything

TX Houston Indeed 7

1.0

★☆☆☆☆

Keep your conscience. Work elsewhere.

Technician (Former Employee) - Houston - August 16, 2015

This place saps your soul. You lie to people all day and only survive if you lie to yourself about what you're doing. I'd say the pay was below industry-standard, but, really, this industry is one-of-a-kind (in a bad way).

✔ **Pros**

. . .

✖ **Cons**

The nightmares

WA Mount Vernon Indeed 1

1.0

★☆☆☆☆

Racist Culture

Health Center Manager (Former Employee) - Mount Vernon, NY - July 29, 2020

Indeed Featured review

The most useful review selected by Indeed

Looking back at the experience, I would say the racism, lack of support and toxic environment was a bit much. It was easy to ignore but after a while it became overwhelming.

✓ **Pros**

Free Parking

✕ **Cons**

Toxic work environment, Racism and Poor Management

Chapter 10

We have thousands of patient reviews, primarily screenshots from Google and Yelp. Large numbers complain of rude or disrespectful staff and callously long wait times.

To have an accurate understanding of patients' experiences and evaluation as a whole, including the positive experiences along with the those who choose to post reviews will be inadequate and a full survey or stratified random sample study would be needed. We're unaware of any such study for Planned Parenthood as a whole or for any individual center.

The worst ones, of course, are from people who claim horrific medical dangers. We include a small number of those below to show that this is another source of knowing about problems; these did not lead to malpractice suits and are otherwise not covered in the chapters above.

IL Aurora Google 1. Accessed 04.29.21.

Morgan Kunert
8 reviews

★☆☆☆☆ 3 months ago

Had a D&c done due to having an empty sac not developing a baby or anything inside it for a while. I will NEVER be back to you guys. I ended up in the ER last night almost septic from an infection. I called all during the week to try to be seen and they just pushed it off. This place is horrible, dirty and very rude staff.

DC Washington Google 1. Accessed 05.17.21.

yvette terry
1 review

★☆☆☆☆ 7 months ago

They where very nice but the punctured my uterus.. and only gave me Ibuprofen I'm in excruciating pain.. they where suppose to call and no call to check on me.. horrible experience

MA Worcester Google 1. Accessed 04.23.21.

Kc P
Local Guide · 4 reviews · 1 photo

★☆☆☆☆ 2 years ago

If I could give zero, I would. After a religious lecture and including my boyfriend in a private lite chat in the hallway without my permission or knowledge when I made it clear I didn't want him in the room, they sent me home telling me I wasn't pregnant.

They did a urine test and an ultrasound.

Five days later I was rushed in to emergency surgery for a 9 week ectopic that almost killed me.

Never, ever, ever go here. I've contacted them and was hung up on, told I had the wrong office, and not a single of my mailings and emails were responded to.

TX Arlington Google 12. Accessed 09.18.22.

Valsal
6 reviews · 6 photos

★☆☆☆☆ a year ago

Highly concerned about the training of personnel here including front desk, Gabriela. She is not Uptodate with ACOG or national cervical cancer guidelines yet feels can deny care without any medical training. Patient was denied pap spear despite meeting national guidelines for indication of Pap smear. Furthermore, she refused transfer to a supervisor to discuss some serious treatment allegations.

Was essentially kicked out of office without the right to speak to someone. This is highly concerning especially when patients are in a vulnerable position and in need of care. Planned parenthood should be following national and specialty specific guidelines and under no circumstances should deny care to any patients!

Please consider speaking to staff especially front desk about treatment and misinforming patients which can have serious consequences.

IL Aurora Google 2. Accessed 04.29.21.

Danielle Stigter
1 review

★☆☆☆☆ 3 years ago

DANGEROUS!!! ALL WOMEN BEWARE!!! Came to this location for prenatal vitamins at 6 weeks and was given the first pill at my visit a couple weeks ago. After a week something was off I didn't feel well. I went back to their office to find out I was accidentally given the first phase of an abortion pill. Needless to say I've lost my baby. And the manager Gabrielle assured me she would get to the bottom of it all. Please women all around visiting this planned parenthood. Be careful and mindful of all that occurs

Problems at Planned Parenthood Website

United States Page

Alabama

Alaska

Arizona

Arkansas

California Overview Page

CA cities & towns: A-F

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CA: S-Z

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Colorado

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Illinois

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Texas: Austin

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Houston & Stafford

Texas:

San Antonio

Utah

Vermont

Virginia

Washington DC

Washington

West Virginia

Wisconsin