Report of the Problems at Planned Parenthood Committee
PDF book version of the Texas pages of the constantly-updated website:

Problems at Planned Parenthood - **www.problemsatplannedparenthood.org**

Texas pages:

Main page, most cities: **www.problemsatplannedparenthood.org/texas**

Austin **www.problemsatplannedparenthood.org/texas-austin**

Dallas and Fort Worth:
www.problemsatplannedparenthood.org/texas-dallas-fort-worth

Houston and Stafford:
www.problemsatplannedparenthood.org/texas-houston-stafford

San Antonio: **www.problemsatplannedparenthood.org/texas-san-antonio**

This report organizes problems with a section for each kind of problem. The website instead reports problems by individual centers or groups of centers.

Not copyrighted. Sharing of information and documentation is encouraged.

PDF version dated 09.08.25

Section 1

Austin (South)

The health department document from 2015 can be found at:

www.problemsatplannedparenthood.org/texas-austin

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."

Staff

- 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 (Southwest)

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, 2017 and 2020 can be found at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Highlights:

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

San Antonio – San Pedro

The health department documents from 2020 and 2021 can be found at:

www.problemsatplannedparenthood.org/texas-san-antonio

Highlights:

Clinic Conditions

- Instruments were washed and sterilized in the same area where dirty, biologically contaminated surgical instruments and medical waste were processed.
- The facility failed to keep medical waste and dirty instruments separated from clean ones, creating cross-contamination.
- There was only one sink and eyewash station. It was located in the same area as the dirty instruments and medical waste.
- sterile instruments intended for surgery were stored in a manner that they were no longer sterile. This created a risk of infection when those instruments were used on patients.
- There were no protective barriers on heating pads. The pads weren't properly cleaned between patients.
- The solution used to decontaminate vaginal ultrasound probes had dust and “unidentifiable debris” in it. The facility was using this solution to sterilize the vaginal probes between uses. This was not corrected and was found to be the case in another inspection a year later.
- In this later inspection, the ultrasound and ultrasound probes were found to be dusty and had pinkish-red stains on them.
- There were red stains (presumably blood) on the walls and floors of all the operating rooms.

Staff

- Staff had no set schedule to clean the operating rooms between patients, and did not appear to be doing so.

San Antonio – South Texas

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.

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.
- The facility had expired supplies including needles and surgical equipment.

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.

Waco

The health department documents from 2019 and 2020 can be found under Waco at:

www.problemsatplannedparenthood.org/texas

The 2019 inspection report is entirely redacted, so the violations are unknown. For 2020: A patient didn't return for a scheduled follow-up appointment and examination after receiving the abortion pill. The facility did not try to contact her, as was then required by Texas.

Section 2

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 official court documents on the Problems at Planned Parenthood website (problemsatplantedparenthood.org).

Austin

Foster

The 2012 Complaint can be found at:

www.problemsatplannedparenthood.org/texas-austin

Excerpt:

4.1 On November 20, 2009, Defendants administered Plaintiff a drug known as Cytotec/Misoprostol ("Cytotec") for cervical dilation. Not only has the FDA not approved this drug's use for cervical dilation, but in fact the manufacturer expressly prohibits its use for that purpose. This is not an example of "off-label" use, but rather is in direct contravention to the labels set forth by the manufacturer.

4.2 The true risks of this drug were not adequately explained. Instead, the consent form merely stated that possible side effects include nausea, vomiting, fever, hot flashes, chills, diarrhea, headache, dizziness, tiredness and back pain.

4.3 In fact, the true risks as stated by its own manufacturer include uterine rupture, uterine bleeding, uterine perforation, severe vaginal bleeding, retained placenta and pelvic pain . . . If those risks were in fact disclosed, no reasonable woman would then choose to use it. Furthermore, it was not necessary to administer this drug to Plaintiff due to previous pregnancies and deliveries and it was therefore negligent to administer it to her.

4.4 As a result of being improperly administered this drug and without Plaintiff's informed consent, on November 23, 2009 Plaintiff thereafter presented to Seton Hospital with severe uterine cramping and severe vaginal bleeding. Retained placenta was ultimately found, a known risk of Cytotec. The administration of the drug caused subsequent surgeries and additional damages . . .

Houston

The 2011 Complaint can be found at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Excerpt:

9. Plaintiff . . . was treated by Defendant Planned Parenthood on May 19, 2009. During this visit, staff . . . prescribed the intrauterine contraceptive device manufactured by Defendant Bayer, Mirena. Staff of Planned Parenthood implanted this device . . . Over the next several months, Ms. Gonzalez developed symptoms such as rashes, hair loss, rapid weight loss, weakness, muscle deterioration, and chronic pain. She returned to Planned Parenthood, but the staff failed to diagnose the cause of such symptoms and failed to remove the Merena device. On December 3, the Merena device was removed. In late December, Ms. Gonzalez was again hospitalized, and later diagnosed with systemic lupus, caused by the product and/or the implantation process.

Section 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.

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
February 28, 2015
March 10, 2015
April 30, 2015
June 2, 2015
August 4, 2015
October 19, 2015
April 17, 2017
October 3, 2017
October 4, 2017
January 31, 2018
March 15, 2018
March 31, 2018
June 29, 2019
June 30, 2018
July 26, 2018
August 1, 2019
October 2, 2019
February 18, 2020
June 12, 2020
November 24, 2020
April 16, 2021
June 9, 2021
July 17, 2021
August 3, 2021

Section 4

Austin

Lenox

	Accused child sex trafficker became victim's guardian by Andy Jechow, KXAN, Austin NBC news affiliate February 6, 2017

Excerpt:

A Del Valle man accused of sex trafficking a 16 year old is alleged to have gained guardianship over the girl, removed her from school, vowed to marry her and at one point threatened to kill her family.

James Aaron Lenox, 51, was arrested Monday afternoon by the Lone Star Fugitive Task Force in the 10200 block of FM 812 in Austin. He has been charged with trafficking a child — causing the child to engage in sexual conduct, a first degree felony . . .

Lenox told police he took the victim to Planned Parenthood in Austin because she had never been to a doctor. He told investigators the victim was worried about having some kind of disease. In an interview, the victim told police she had sexual encounters with Lenox . . .

	Warrant: Central Texas man forced teen into sex, threatened to 'kill her family' by Tyler White, *San Antonio Express News,* February 7, 2017

Excerpt:

Lenox also allegedly took the girl to Planned Parenthood to get an IUD implanted, the documents said.

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.

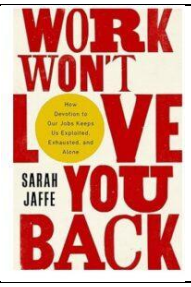
Section 5

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.

	*Work Won't Love You Back: How Devotion to Our Jobs Keeps Us Exploited, Exhausted, and Alone* by Sarah Jaffe, Bold Type Books, January 26, 2021

Book Excerpt, Page 170:

In Texas, around twenty staffers were laid off in April 2020, and they suspected it was retaliation for their union drive. The workers had raised issues around the lack of personal protective equipment and paid sick leave. "There's this big disconnect between the people managing us and the work that is being done on the ground," Ella Nonni, one of those workers, told reporters.

Austin

Dalton

The 2017 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 . . .

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 . . .

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 2019 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.

Section 6

A South Jersey nurse practitioner is suing Planned Parenthood alleging race discrimination.

by Sarah Gantz, *The Philadelphia Inquirer*, April 18, 2023

Excerpt:

The cases detail how inappropriate behavior, racist tropes, microaggressions, and unequal expectations went unchecked, even after employees complained. A few examples . . . A lab manager in Texas was repeatedly berated by her supervisor, whose criticism often centered on her Vietnamese heritage. “It’s so annoying that you can’t speak English,” the manager once screamed at her, she said in a complaint filed in 2019. The Planned Parenthood affiliate settled the case with undisclosed terms.

Section 7

Overbilling the Government

The Press Release of the U.S. Attorney's Office for the Eastern District of Texas can be found out:

www.problemsatplannedparenthood.org/texas-houston-stafford

Excerpt:

Houston-based Planned Parenthood Gulf Coast has paid $4.3 million to resolve civil allegations under the False Claims Act in the Eastern District of Texas, announced U.S. Attorney John M. Bales.

The government alleges that between 2003 and 2009, Planned Parenthood Gulf Coast billed and was paid by government programs, Texas Medicaid, Title XX, and the Women's Health Program, for certain items and services related to birth control counseling, STD testing and contraceptives when such items and services were either not medically necessary, not medically indicated or not actually provided.

Section 8

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.

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

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. Her's an example:

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.

When we had an intern call Planned Parenthood centers to check on who their local mammogram referrals were, we found that about a quarter of the phone numbers never answered or left her on hold until she gave up. To document this and to specify which centers have this problem, we've listed the centers where reviews indicate having phone trouble. That also comes to about a quarter of the centers.

We don't include those where one person had trouble once, which can be a fluke, but only where people tried several times to reach them without success. In some cases, this included having specific medical problems due to the inability to reach them.

Texas (outside of major cities)

- Addison
- Paris
- Spring

Texas - Houston and Stafford

- Northwest
- Southwest
- Stafford

Texas - San Antonio

- Richland Hills
- Northeast
- San Pedro
- South Texas

Articles of special interest for all states:

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025
	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

Compilation of reviews on specific topics:

	**Reviews Report - Medical Dangers**
	**Reviews Report - Racism**
	**Reviews Report - Employee Rights**
	**Reviews Report - Financial Ethics**

Texas pages:

Main page, most cities

Austin

Dallas and Fort Worth:

Houston and Stafford:

San Antonio:

Members of the Problems at Planned Parenthood Committee:
Rachel MacNair, Sarah Terzo, Thad Crouch

Interns: *Anna Connor, Ashley Moorman, Josephine Moorman, and Regina Thompson*

Graphics: Sonja Morin.

Contact:

811 Emanuel Cleaver II Boulevard, Kansas City, MO 64110

info@problemsatplannedparenthood.org

Voice: 816-753-2057

Send:

- *any questions or comments*
- *any documentation of further problems*
- *requests for later updated editions*