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

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

Missouri page: **www.problemsatplannedparenthood.org/missouri**

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

Missouri currently has a total of nine Planned Parenthood health centers.

PDF version dated 02.23.26

Section 1

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.

Section 2

This section doesn't 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 official court documents on the Problems at Planned Parenthood website (**www.problemsatplannedparenthood.org/missouri**)

Independence

Isabel

The Malpractice Complaint can be found under Independence at:

www.problemsatplannedparenthood.org/missouri

Excerpt:

3. On March 5, 2014, Plaintiff went to the office of Planned Parenthood . . . in Independence, Missouri for a normal periodic well woman examination . . .

4. The *CT/GT* Combo-SWAB was completed, but the Thin Prep RFX -ASCUSLSIL was not completed. Plaintiff was informed at the time of her pap smear that she would be notified of any abnormality in her test results and thus assumed because she was not notified that all of her pap smear tests were normal.

5. For reasons unknown to Plaintiff, the Thin Prep RFX-ASCUS-LSIL was never obtained and Plaintiff . . . was never informed that the test was not obtained.

6. Plaintiff returned to Planned Parenthood on June 1, 2015 for a well woman visit and a pap smear was obtained again. The CT *IGT* Combo-Swab test was completed and this time a ThinPrepIHPV Combo was performed and the test was abnormal. There

was a high grade squamous intraepithelial lesion (HSIL) encompassing: moderate to severe dysplasia (CIN *21* CIN *31* CIS) . . .

7. Plaintiff was subsequently advised that she had cervical cancer and her physicians
advised her to have a hysterectomy performed, which was performed on January 8, 2016 . . .

11. The negligence of Defendants directly caused or directly contributed to cause a 14 month delay in diagnosing pre-malignancy or malignancy and as a direct result of the delay, Plaintiff had to undergo a hysterectomy.

St Louis . .

Analla

The 2003 Malpractice Complaint can be found under Tier 1 - St. Louis at:

www.problemsatplannedparenthood.org/Missouri

Excerpt:

12. That on or about November 10, 2001, at RHS's facility in the City of St. Louis, defendants purported to perform on Analla a first trimester vacuum aspiration abortion of a fetus with an estimated gestational age of five weeks.

13. That on or about December 19, 2001, at her home in Johnston City, Illinois, Analla partially delivered a deceased baby.

14. That on or about December 19, 2001, at Marion Memorial Hospital . . . Analla completed the delivery of a deceased baby with an estimated gestational age of between twenty-one and twenty four weeks . . .

Davies

The 2005 Malpractice Complaint can be found under Tier 1 - St. Louis at:

www.problemsatplannedparenthood.org/Missouri

Excerpt:

5. On or about August 6, 2003, Ms. Davies underwent a left breast exam due to complaints of left breast pain for three months . . . The diagnosis from the exam and visit was "breast pain".

6. No follow-up evaluation was ordered for this breast abnormality . . .

11. On October 25, 2004, she underwent a left mastectomy. This revealed invasive micropapillary carcinoma . . . Ductal carcinoma in situ was also seen.

12. According to the pathology report, the diagnosis was a Stage II-A invasive micropapillary carcinoma of the left breast . . .

16. As a direct and proximate result of the negligence of this Defendant as aforesaid, Plaintiff has sustained the following damages:

1) Plaintiff has incurred substantial medical bills, pharmaceutical bills and hospital bills in the past and will continue to do so in the future;
2) Plaintiff has sustained severe physical and mental pain and suffering in the past and will continue to do so in the future . . .

Gibbons

The Malpractice Complaint can be found under Tier 1 – St. Louis at:

www.problemsatplannedparenthood.org/

Excerpt:

12. On November 22,2015, Alexis was seen by Dr. Michael Perosa and was told that Jackson Gibbons had Anencephaly and that Jackson Gibbons would not survive.

13. After consulting numerous doctors, Plaintiffs made arrangements to have a surgically induced abortion by standard dilation and evacuation (herein "D&E") at Planned Parenthood's Reproductive Health Center . . .

15. On December 7, 2015 Plaintiffs spoke with Dr. Grentzer to make it clear that they wanted the body of Jackson Gibbons and that Baue Funeral home would perform the cremation and ceremony . . .

[*After many unsuccessful contacts about receiving the remains*]

33. On or about January 14,2015, Alexis received a call from Washington and [iii]' Hawthorne who stated that the body ofJackson Gibbons was discarded by Defendant Pathology Services.

34. Plaintiffs stated they were going to have Baue Funeral Home make hand and foot
prints for them of Jackson Gibbons . . . and that they had purchased an urn and planned to keep Jackson Gibbons' remains on a shelf in their home as a memory of him . . .

46. The Defendants' by their extreme and outrageous conduct intentionally and/or reckless caused severe emotional distress and mental anguish to the Plaintiffs. The Defendant intentionally and recklessly caused severe emotional distress to Plaintiffs by the mishandling of their son's body after he had died.

Jones

The Malpractice Complaint can be found under Tier 1 – St. Louis at:

www.problemsatplannedparenthood.org/missouri

Excerpt:

7. After initial tests were performed, an abortion was scheduled for January 9, 2015 . . .

9. After the procedure was completed, the tissue extracted from Brittany's body was sent to a pathology lab for testing.

10. The pathology lab report indicated that there was no fetal tissue present.

11. [The doctor] never informed Brittany that the abortion was not fully performed and that no fetal tissue was removed from Brittany's body.

12. [The doctor] never informed Brittany that . . . no fetal tissue was removed from Brittany's body.

13. As a result . . . a fetus came out of Brittany's body while she was at her apartment, alone, along with a significant amount of blood.

Peal

The Malpractice Complaint can be found under Tier 1- St. Louis at:

www.problemsatplannedparenthood.org/missouri

Excerpt:

4. That on or about May 26. 2018 Plaintiff was determined to be approximately 10 weeks. 2 days of gestation and underwent a therapeutic abortion . . .

7. That on June 29. 2018 Plaintiff was again seen at the aforesaid Defendant Planned Parenthood's facility . . . and on ultrasound it was found that Plaintiff was still pregnant with a 15 week one day fetus. Plaintiff subsequently had another therapeutic abortion procedure . . .

8. Plaintiff's post-operative course was complicated by readmission to Barnes Hospital on July 2. 2018 where she was diagnosed with sepsis secondary to endometritis/an Infected uterus and she was treated with antibiotics and subsequently a third D&E.

9. That Plaintiff's damages. expenses and injuries from the supplemental abortions were directly and proximately caused and contributed to be caused by the carelessness, negligence and deviation from appropriate standards . . .

a. If no specimens were. in fact. sent to pathology from the May 26. 2018 therapeutic abortion, then this would be a deviation from standard of care;

b. Alternatively. if products of conception were, in fact, sent to pathology . . . but no villi were determined to be present. that would be a deviation from standard of care.

Quaka

The 2014 Malpractice Complaint can be found under Tier 1 – St. Louis at:

www.problemsatplannedparenthood.org/missouri

Excerpt:

12. During the D& C surgical procedure on or about October 5, 2010, plaintiff's cervix was perforated and lacerated with a surgical instrument . . .

14. Defendant Planned Parenthood's post-operative medical report acknowledged and recorded the perforation and laceration of the cervix.

15. Sald wound to the plaintiff's cervix posed a foreseeable and substantial risk of infection . . .

18. Defendant Planned Parenthood did not perform a culture on plaintiff to determine the potential presence of infectious bacteria, including beta hemlytic strep.

19. Following the D & C surgical procedure, defendant permitted plaintiff to return home the same day.

20. On or about 3:55 p. on October 10, 2010. plaintiff called defendant Planned Parenthood to report on her physical condition and seeking medical advice and follow-up treatment . . .

25. Plaintiff went to the Emergency Room . . . October 11, 2010 . . .

29. On October 12, 2010, Plaintiff was examined by defendant Planned Parenthood . . .

39. At the conclusion of e October 12, 2010 examination and testing, the defendants made an incorrect dia osis regarding plaintiff's complaint and physical condition of pelvic pain seconda to gastroenteritis.

40. At the time defendant made the erroneous diagnosis, plaintiff was suffering from a beta hemolytic s ep infection introduced through the wound of her cervix.

41. Defendants failed to eat plaintiff for a beta hemolytic strep infection.

42. As a direct and proximate ause of defendants failure to diagnose and treat plaintiff’s beta hemolytic str p infection, the infection continued to spread and worsen.

43. On or about October 4,2010, plaintiff sought treatment at the Emergency Room of St Clair Hospital.

44. The Emergency Room physician called defendant Planned Parenthood to obtain detailed information regarding plaintiffs history and condition . . .

46. [The doctor] failed return the can or otherwise contact the St Clair Hospital . . .

47. On or about October 5.2010, plaintiff was admitted to Barnes-Jewish Hospital.

48. She was diagnosed with sepsis, peritonitis with a surgical abdomen, an ileus and pyoslpinx and purulent pelvic and abdominal ascites.

49. She was subsequently additionally diagnosed with Toxic Shock Syndrome and septic shock.

50. Said diagnosis and maladies suffered by plaintiff were directly and ,proximately caused by the failure of defendants to appropriately diagnose and treat the underlying beta hemolytic strep infection.

51. Said maladies cause plaintiff to become severely ill and required her hospitalization for an extended period of time, including in the Intensive Care Unit.

52. Plaintiff was caused to undergo intrusive medical procedures including laparoscopy, gastric lavage and placement on a ventilator.

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.

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

Section 4

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

Discontent at the organization had already been brewing before the pandemic. An employee satisfaction survey taken last year revealed widespread unhappiness among rank-and-file employees, who complained of a lack of transparency, pay inequities and a top-heavy management structure . . .

While the overwhelming majority of employees surveyed said they found their work meaningful, only 31% said they were given career development opportunities, only 34% said different work units worked well together and only 39% responded affirmatively to the statement, “The environment at this organization makes employees in my work units want to go above and beyond what’s expected of them.” . . .

The organization has experienced a high rate of employee turnover – as many as half its nearly 150 employees left in the past year . . .

Ulanowski recalled a time when Hill, addressing employees’ complaints that they were overworked, underpaid and under a great deal of stress, said that “everyone just needs to be sedated.”

Harris

The Complaint can be found under Tier 1 – St Louis at:

www.problemsatplannedparenthood.org/missouri

Summary: A security guard claims he was fired on the basis of a “bizarre accusation” that unfairly maligned his character.

Section 5

Kansas City

Carter

Excerpt:

1. Plaintiff is an African-American female, residing in Jackson County, Missouri . . .

12. Plaintiff began working for Defendant PPGP on or about April 20, 2011 as an office administrator and HR assistant, and was ultimately promoted to HR Generalist in 2015.

14. After Defendant McQuade took over as CEO, Plaintiff began noticing that African American employees and candidates were being treated differently, including in hiring, pay, discipline, and workload, resulting in a large amount of turnover of African American employees.

15. When two Caucasian employees used a racial slur in the presence of an African American employee, Defendants PPGP and McQuade did not see the situation as serious and only imposed write-ups on the offending employees.

16. At one point, Defendant McQuade made clear that she believed that black employees were colluding with each other and sharing information behind her back.

17. After more than four years with the organization, with satisfactory performance reviews and no disciplinary record, Plaintiff was suddenly, and without warning, placed on a Performance Improvement Plan (PIP), citing both performance issues from months prior that had already been resolved, as well as fictitious incidents.

18. Plaintiff refused to sign the PIP, believing that it was unfair and based on discriminatory reasons.

19. Upon information and belief, white employees who had committed violations of policy or had performed poorly were not placed on PIPs, particularly for issues based months in the past.

20. Plaintiff complained to management about racial disparities in the workplace, and that her PIP was racially motivated, but no investigation was undertaken or resolution reached . . .

24. On or about October 30,2015, Plaintiff submitted her letter of resignation, citing that she believed she was being unfairly targeted due to her race, and that it was causing her undue stress. Defendants accepted Plaintiff's resignation with immediate effect.

Williams

Excerpt:

16. Plaintiff began working for PPGP on January 29,2000 as a Security Services Coordinator.

17. In 2002 or 2003, Plaintiffs job title was changed to Director of Securities and Facilities.

18. In 2014, Defendant McQuade took over as Defendant PPGP's CEO.

19. Defendant McQuade quickly began creating and filling executive positions, passing over Plaintiff in the process.

20. At the time of Plaintiff's termination, there were no African Americans on the executive committee and, upon information and belief, no African Americans have served on the executive committee since Defendant McQuade took over.

21. Over the approximately two years that Plaintiff and Defendant McQuade worked together, McQuade treated Plaintiff differently than her non-Black colleagues, including in requests for time off and, upon information and belief, pay.

22. Defendant McQuade also began discouraging Plaintiff from taking part in an annual conference in 2014 despite the fact that Plaintiff routinely attended these yearly conferences for the Planned Parenthood Federation, PPGP's parent organization.

23. In 2015, Plaintiff was similarly discouraged from attending the annual conference by Aaron Samuelcek, the organization's COO and Plaintiff's direct supervisor.

24. At numerous points, Plaintiff discussed concerns with Defendant McQuade regarding the organization, including concerns regarding the treatment of minority employees.

25. At various times, Defendant McQuade would raise her voice at Plaintiff, attempt to tum Plaintiff and African American friends/coworkers against each other, and on at least two occasions accused Plaintiff of thinking that Defendant McQuade was a racist.

26. Toward the end of20l5, Defendant McQuade began increasing Plaintiffs workload to the point she had difficulty keeping up, and also rejected Plaintiff's request for additional staff to help with the workload despite providing Plaintiff's white colleagues with assistance . . .

29. As a result of the unmanageable workload, stress, and discriminatory treatment, Plaintiff began having health problems in the latter part of20 15, including numbness in her face and arm, headaches, and heart palpitations.

30. On December 13,2015, Plaintiff's heart rate escalated to more than 170 beats per minute, resulting in Plaintiff having to be rushed to the hospital and admitted.

St. Louis

	Former St. Louis Planned Parenthood employee sues for racial discrimination by Deion Broxton, First Alert Channel 4, June. 6, 2024

Section 6

Indeed.com is a site that among other things provides a place for employees to give reviews of their employers. We offer some examples here.
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MO St Louis Indeed

1.0

★☆☆☆☆

little work/life balance and unfair treatment of employees

Coordinator (Former Employee) - St. Louis, MO - October 17, 2014

Typical work day included patients being upset about being misquoted prices on the phone. The wait times were extrememly long even before I started working there. I learned that you will be asked for input but it will not be considered it is just to 'shut you up'. Management is not very good. They micromanage and have very little sense of how the health center operates. The co-workers are pretty good. They can be sort of teamed up with one another and make the job more difficult that it needs to be. The hardest part of the job is that learning price for services and there is still no real sense of it. The most enjoyable aspect was the patients. Their different stories are wonderful and even their personalities are great.

✓ **Pros**
Patients become like family

✗ **Cons**
no group lunches, lack of recognition by senior management, benefits are expensive, no room for advancement, no real training system is in place

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

MO Independence Indeed

1.0

Horrible employee treatment

Medical Assistant (Former Employee) - Independence, MO - July 3, 2019

I worked here for 2 1/2 years thinking that it would change over time but no. For you to accumulate 1 vacation day you would have to wait 1 1/2 months so that you would have the whole 8 hrs paid. Managment was a joke. Several times I was told via email that my time off would be approved but when time came they would tell me that no my time was not approved. So you couldn't even take their word. When it came to seing patients you are expected to see 40+ patients that are scheduled 10 min spots. There where many times where I would help out in several locations and received no recognition for the type of work I did.

I am all for their mission but employee treatment is horrible. All the hard work you put in it for nothing.

✔ **Pros**
I cant think of anything that people would benefit from this place

✖ **Cons**
Healthcare is very high, stressful enviroment

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 nation-wide. In Missouri, 6 out of 9, or two-thirds, indicate this might be a problem at least at some times.

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.

Missouri-

- Columbia
- Gladstone
- Independence
- Kansas City
- Springfield
- St. Peters

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**

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Send:

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