PITTSBURGH COMMISSION ON HUMAN RELATIONS
Minutes of Meeting
April 4, 2011

Attendance: Adelaide Smith, *Chair Pro Temp*

Winford Craig	Lorraine Eberhardt
Gerald S. Robinson, III	Lynette Drawn-Williamson
Lee Fogarty	Eric Horwith
Leah Williams-Duncan	Mary K. McDonald

Called/Unable to Attend:

Rev. Timothy L. Smith, Sr	Amanda Rubio
Curtis A. Smith	Neil Parham
Elizabeth Pittinger	

Staff: Charles Morrison, *Director*
W. Kevin Trower, *Solicitor*
Connie Miskis Zatek

Guests: Jay Dworin, FHP
Dr. Samuel Tisherman, Presbyterian Trauma
Melissa Miklos, Program Manager, IRB
Tina Vita and Pam Fazio, Assistants to Dr. Tisherman

I. CALL TO ORDER

The meeting was called to order at 3:40 p.m. by Commission Chair, Adelaide Smith. Mrs. Smith suspended the business portion of the Commission meeting in order to allow for a presentation of the University of Pittsburgh Institutional Review Board.

II. PRESENTATION OF THE UNIVERSITY OF PITTSBURGH IRB

The Program Manager, Melissa Miklos, began with a brief overview of the work of the IRB, which reviews all research that involves human subjects. Physicians, nurses and community lay people review protocols to make sure they make sense; that consent forms are understandable; and review research to insure that all procedures conducted are appropriate and respect the individual's rights, privacy, etc. The IRB reviews are required compliance with the Department of Health and Human Services and the Federal Drug Administration, as well as making sure there is informed consent – unless it has been waived or if the person cannot provide it on their own behalf.

Dr. Tisherman stated that the instant project involves people who cannot give consent and where time is of the essence. He acknowledged a potential conflict of interest in the research as he has submitted a patent application and is in position to make royalties in the future, if the research/testing is successful. A colleague, Dr. Forsythe, has no conflict and can handle questions.

This research project is titled, "Emergency Preservation Resuscitation (EPR) from Trauma." It involves instances where the patient suffers cardiac arrest from trauma and the chance of survival is ten percent or less. Standard ER procedure would to provide fluids, blood, open the chest and start open heart massage. Dr. Tisherman stated that there is only seconds to bring someone back before the brain is attacked. For the last 20 years, trauma units have been using cooling to buy time – very quickly cooling the body to very low temperatures in order to control bleeding. This requires use of ice and cold fluids to bring the body temperature down to 50 degrees Fahrenheit and then employ the use of heart-lung machines. According to Dr. Tisherman, this method is used all the time in critical surgery, but it has never been used in trauma cases.

The prospective patients would be those with penetrating trauma injuries such as gun shot wounds or stabbings. (Injuries of this type sustained by a car accident have a near zero chance of survival.) The age range for research subjects is 18 – 65 years. They cannot be in cardiac arrest for too long, have non-repairable head injuries, or be in flat line arrest. Prisoners and pregnant women are also excluded from the study.

The procedure to be used at the trauma center would be to give fluids, open the chest and if after a minute nothing is working, the trauma physician will switch to the EPR protocol. The body will be flushed with ice cold fluids directly into the heart cavity. In the operating room, the patient will undergo full pulmonary by-pass to stop the bleeding.

When questioned about risks and benefits, Dr. Tisherman said the single greatest benefit is survival. However, this may come with some risks. The body needs to clot the blood, but cooling decreases the clotting factor. There is greater risk of infection. No blood flow gives rise to possibility of stroke, and the patient could survive the initial trauma with brain damage. Dr. Tisherman stated that all of this could occur with a heart attack, too, and their objective is to minimize the risks.

The anticipated outcome is to have the patient leave the hospital with no or minimal brain damage. The patient will be monitored for six months following discharge from the hospital for complications.

This research is sponsored by the U.S. Army and is being overseen by both Army personnel and the FDA.

Dr. Tisherman emphasized that emergency room personnel must make a decision within moments of a patient's entry into the ER. There is no time to talk with the family until afterward, at which time the family can give consent or opt out of the research program. Even so, the patient's progress will continued to be monitored. The program administrators are aware of the need to offer patients or potential patients the ability to opt out. Currently, plans call for advertising, community consultation, phone contacts and website information. If someone wants to opt out they will receive a bracelet or other appropriate identifying information should they end up one day at a trauma center in need of emergency care.

Commissioner Adelaide Smith asked how these bracelets will be distributed and whether not a person's decision to not want intervention will be made a part of a record or file.

Dr. Tisherman responded that the program coordinators are trying to advertise the study via various media outlets, on buses, television, etc. If a person calls requesting the pt out bracelet, it will be sent to them.

Director Morrison reiterated that the ideal research subject would be someone suffering from a gun shot wound or stabbing. He stated "In Pittsburgh, statistically, more than likely that would be a young African-American male," and asked if this study is being conducted anywhere else in the country.

Dr. Tisherman said that there are several other centers interested, but Pittsburgh is initiating the project along with the University of Maryland.

Director Morrison inquired about the role of the Department Defense. Dr. Tisherman explained that military personnel cannot be involved in the program. However the military are aware that they would have the greatest need for using this type of medical procedure in the future. The protocol is currently being reviewed by the U.S. Army and will begin once they complete their review.

Dr. Tisherman noted that the last study was conducted at ten centers across the country and involved cardiac arrest following blunt trauma. The instant study differs in that it involves penetrating trauma. Feasibility and safety trials are necessary to show that the procedure can work and later will be expanded to include other emergency centers. He anticipated that this study will be small – possibility only ten patients initially, and they will have to conduct other studies on another ten or so if the first is successful.

Dr. Tisherman went on to outline some of the differences between the study with cardiac arrest from blunt trauma and the instant study involving penetrating trauma. He noted that the first study was a blind trial study in which hundreds of people at the ten trauma centers were enrolled into the study. The population was much different, too.

Commissioner Williams-Duncan asked Dr. Tisherman exactly what is being asked of the Commission today. He replied that he is looking for input, suggestions, etc. He stated that the research group will be speaking at other events around town, discussion groups, surveys at trauma clinics, etc. for additional input. Dr. Tisherman acknowledged that no one knows best how to do this kind of "thing" and felt it appropriate that the Commission is willing to serve as a community sounding board for suggestions, which will, in turn, be taken back to the IRB for further discussion and consideration.

Jay Dworin of the Fair Housing Partnership of Greater Pittsburgh, noted that in actual circumstances it will not be likely to receive prior informed consent and an acknowledgement has been made that target subjects in Pittsburgh may primarily be African-American males, therefore, "What are your intentions about speaking with the African-American male community?" He also commented that an "opt out bracelet" may not be the ideal device for this and suggested the use of a sticker on a driver's license.

Commissioner Williams-Duncan raised concern that in not opting out, "everyone is in" and the African-American community is at high potential for gun shot wounds. She asked how to best address this community. She expressed concern that the target population is probably the very people who will opt out.

Commissioner Robinson raised further concern that even should the IRB go into the various communities with detailed information about the research study, are the people who would benefit most even come to those informational meetings?

Dr. Tisherman stated that the University of Maryland currently has surveys available at trauma clinics providing necessary information, as patients at trauma centers tend to be repeat patients. Other cities are using telephone surveys based on randomized digital dialing.

Commissioner Drawn-Williamson asked if the consent form can be given to a guardian to sign. Dt. Tisherman responded that at the time of the initial injury a parent or guardian is not around and if so, there is no time for that person to think through the pros and cons of the procedure. A decision must be made within a minute or two at most.

Commissioner Horwith suggested that as the Commission may not have the knowledge in this area to provide medical perspective the IRB contact Dr. Judy Black of POST, who is responsible for implementing a similar consent form with regard to a person's fundamental rights and respect.

Commissioner Williams-Duncan again expressed serious concerns with the study and its target population. She said if something unforeseen comes of the study, she would hate to see the Commission's name on it as having reviewed the plan. Commissioner Horwith agreed, especially as the population most likely targeted has little or no voice.

Commissioner McDonald disagreed noting that if the survival rate for conventional treatment is only ten percent, this protocol would present much better opportunity for survival following penetrating injury.

Solicitor Kevin suggested that in addition to groups like the Commission, the research team needs to meet with various groups of that particular demographic, perhaps starting with an audience at the University of Pittsburgh. "They will give you some of their concerns. If you talk with a young guy who has a reasonable expectation of sustaining a gun shot wound and said to them, 'Do you want to die or would you like us to save you,' I think they will say yes. On the other hand, if you wrap it in experimental language, I don't want to be anyone's guinea pig." He also suggested if this same study was conducted in New Mexico the age demographic may be similar but the race would be different.

The Solicitor also pointed out that his experience has been that a response is better if the speaker is of the same age and looks like his audience; it lowers the potential barriers and allows for better communications. Since young African-American males are the group this procedure is likely to help, "it makes sense to

present information to them and they may provide some really good ideas. They might also lead you to other people and websites that folks in that demographic go to religiously – then you can get your money's worth."

Dr. Tisherman reiterated that soldiers are the largest population that sustains penetrating injuries and the goal is to save as many lives as possible, but the military cannot be involved in this research study due to consent issues. Once the initial study is launched, medical personnel will find better ways to enhance the protocol to achieve even better results. Only major trauma centers would have the appropriate medical personnel available and the volume of injuries to make this study possible.

The plan is to train a small number of people how to do the mechanics of this study. All of the elements and personnel would have to be available at the time a potential research subject enters the trauma area. Dr. Tisherman estimated that the objective is to get five to ten subjects within a year. He anticipates beginning the actual study within the next three to four months, perhaps longer.

Dr. Tisherman explained that the same methods would be used to give outcome results back to the community – group presentations, various media sources, community discussion, etc.

Jay Dworin stated that although survival is a potential benefit, one of the real potential risks is living with brain trauma. "If so, what will be the resources available for assuring the individual who ends up with substantially diminished brain injury as a result of the study receives the necessary care after the project is completed?

Dr. Tisherman acknowledged this is an insightful and difficult question to answer. He stated that brain injury can happened even without the person being a part of the study. The hospital will cover the cost of any immediate problems that result from participation in the study but long term care not been fully discussed. Commissioner Horwith noted that this would make it even harder to give consent.

Solicitor Trower noted that this demographic believes that no one gives a damn about them, so an important part of marketing would be to tell them that you do care and that this medical initiative is focused on their survival.

Commissioner Drawn-Williamson also noted that this particular group of people are likely to not have medical insurance coverage. The Solicitor reminded

the Commissioners that most of the benefit of research is to help the next person. "The medical world may learn something from this which will be used to save the next person."

Commissioner Williams-Duncan countered that "it is called a study because we don't know if it will work. Someone has to make the decision who gets the procedure or not . . . "

Commissioner Horwith asked if medical social workers are also involved in the protocol to insure that information is provided, clearly understood, and respects the rights of the individuals. Dr. Tisherman responded that once an individual arrives in the trauma center, the medical staff goes to work immediately, with much happening at the same time. Part of the procedure is that the Emergency Department is alerted and a social worker is dispatched to talk with the family.

Commissioner Robinson inquired how the research study procedures compare to that of conventional treatment with regard to risk factors. Dr. Tisherman explained that research centers in both Boston and Pittsburgh have been working with animals in similar studies and have cooled the bodies to the point of no blood flow for nearly three hours. The animals have been resuscitated and then do well. The comparison for this to standard treatment is that there is no survival. With the instant protocol, all test subjects have survived. He acknowledged that with longer cooling times some patients will have neurological problems.

Commissioner Craig asked whether outcome reports will indicate damage, etc. Dr. Tisherman replied affirmatively, stating that the reports will also look at neurological brain function out to six months following treatment.

Dr. Tisherman stated that in a trauma world, medical personnel never look to see whether a person has insurance, what their color or race is, why they are there, etc. "Doctors and nurses work solely to save lives." He promised to keep the Commission abreast of the study as it moves forward.

The Chairperson thanked Dr. Tisherman for sharing his information. The presentation of the IRB was concluded at approximately 4:45 p.m.

Following a very brief break, Director Morrison introduced Jay Dworin of the Fair Housing Partnership, who was invited to speak to the Commission about its housing testing program.

Mr. Dworin explained that the FHP advocates for victims of housing discrimination. He said the greatest tool to find evidence of discrimination is testing. FHP does this with matched pairs of testers. The FHP maintains a pool of

people whom they train on fair housing laws and practices and who are then dispatched to a dwelling to view property for rent or sale. Mr. Dworin explained that two testers are usually sent to each property -- a matched pair. This means that a tester is assigned a profile similar in financial background, employment and rental history, education, family status, age, etc. to the person who made the original complaint of discrimination. A second tester is the "control" whose profile is different in that area which is the protected class of the victim. As an example, Mr. Dworin told of the following case.

In a race case, a couple called to view an apartment. An appointment was made over the phone. At the door, the landlord said that he a problem renting to black tenants. (He had thought the caller was white when the appointment was made.) A matched pair white tester was asked to make the same call to the same landlord. This time the landlord asked the caller directly if he was black or white. A black tester contacted the landlord but he never received call back.

A similar situation occurred with the second set of matched pair testers. The black tester was asked he was black or white and was then given the story of no vacancy. The next tester, a white woman, called and set an appointment, but a black gentleman showed up at the door and was told that he had the wrong address.

Mr. Dworin said that it is easier to find cause with the help of testing results. He stated that the above situation is an example of complaint-based testing. The FHP also does audit-based testing which tries to get a feel for what is going on in a neighborhood without having an actual complaint. In these cases, the FHP does data analysis, looking for very specific situations. For example, there is an area of white residents and then there is a "line of demarcation" which begins the area of black residents. Mr. Dworin said that the FHP "looks for areas of seepage."

Testers are volunteers who are paid a small stipend for their time and effort. They are recruited everywhere – from the Hispanic Center, universities, behavioral and mental health clinics, etc. depending on what is being tested. Testers go through three hours of training in which they learn about fair housing laws, the testing process, etc. Mr. Dworin said that he will let Director Morrison know of the date for the next training class, should Commissioners be interested in becoming a tester, too.

The FHP is currently waiting for new census data. They are working with Carnegie Mellon University and the University of Pittsburgh regarding area demographics. Currently the FHP conducts about ten testing surveys for audits, but Mr. Dworin indicated that they "need to ten times that in order to get a better sense of what is going on."

Once the FHP tests are completed, the information is turned over to the Commission to investigate further and/or initiate a complaint.

Mr. Dworin spoke briefly about FHP testing for the hearing impaired. The use of a telephone relay system results in a printout of the telephone conversation, sometimes making it a little easier to prove discriminatory treatment.

Mr. Dworin also touched on design and construction, explaining that all buildings built after March 1991 with four or more units must be built with accessible features. He stated that new construction often is not in compliance. Rehabilitated buildings are not included in this law, but add-ons are. Mr. Dworin said that case law in this area differs with at least three widely different opinions, and HUD has not made a definitive decision regarding it.

It was noted that the Spanish population in Pittsburgh is very, very small with the majority being concentrated in the Beechview community. Mr. Dworin reported that there are two landlords in that community who own almost all of the property where Hispanics live. The majority is undocumented and as such, cannot make a formal discrimination complaint.

Solicitor Trower inquired in situations where a building inspector misses an issue of non-compliance if anyone has added the building inspector as a defendant in a charge. Mr. Dworin admitted that if the FHP were to make the decision to "go after" the City of Pittsburgh, it would not go alone. FHP currently has an architect on staff.

The Solicitor stated that he can see situations where blueprints are not in conformity and the building inspector misses it. The case can go to state court and the respondent made to defend it. He spoke of a situation where a deck was built and the railing was not high enough. A child fell off and died. It was found that the inspector approved the deck even though the railing was 13 inches too low. This would be an opportunity to bring the city to court for building neglect, as well as charging the building inspector with neglect. The Solicitor said "if they have to pay, changes happen faster."

Mr. Dworin was thanked for his information and invited to attend another Commission meeting in the near future.

II. ADOPTION OF MINUTES

The Minutes of the March 7, 2011, Commission meeting were unanimously adopted as mailed upon motion of Commissioner Williams-Duncan and second by Commissioner Fogarty.

Due to the lateness of the hour (5:10 p.m.) and the fact that several Commissioners could not remain longer, the Chairperson continued this meeting until May 2, 2011.

/cmz

Pittsburgh Commission on Human Relations
Director' Report
March 25, 2011

Mar. 03, 2011	Director Morrison attended the program entitled "Women Around the World: Achievements and Challenges Today," sponsored by the World Affairs Council of Pittsburgh and YWCA of Greater Pittsburgh. The program included a panel discussion with a diverse group of international women and their perspectives on major contemporary issues confronting women around the world.
Mar. 10, 2011	Director Morrison attended a program at the University of Pittsburgh School of Social Work entitled "Intergroup Relations/Implicit Bias," where the discussion examined the subtlety of contemporary (implicit/unconscious/subtle) racism and its continued effect in negatively impacting societal efforts to narrow and/or eliminate disparities that exist between Caucasians and African-Americans in the United States.
Mar. 21, 2011	Director Morrison attended the meeting of the City of Pittsburgh/Allegheny County Task Force on Disability. Topics discussed at the meeting included funding for the work of the Task Force, the results of the groups representatives meeting with the Mayor (to discuss issues such as sidewalk safety, audible traffic signals, emergency preparedness, new ADA standards, etc.

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Journey towards housing fairness continues

Charlene Crowell

Commentary

When the Center for Responsible Lending examined the demographics of the housing crisis, it determined that for every 100 African-American homeowners with a mortgage, 11 have either lost their homes or were at imminent risk of foreclosure. For Latino families, the figures were even worse—17 of every 100 Latino homeowners with a mortgage are affected by foreclosures. From 2009-2012 African-American and Latino communities will together lose $350 billion due to depreciation in values from nearby foreclosures.

Just as communities of color were targeted for high-cost subprime mortgage loans, now the high concentration of foreclosed properties in these same communities has led to yet another dilemma: a disproportionate share of neglect among bank-owned foreclosures. Also know as real-estate owned properties, these formerly-occupied homes are bringing blight and contributing to further deterioration of the quality of life in communities of color.

A new report from the National Fair Housing Alliance in Washington, D.C., describes an investigation of 624 bank-owned properties in four markets: Dayton, Ohio; Hartford, Conn.; Maryland's Prince George's County; and Richmond, Va. Field staff visited and evaluated the exterior condition of REO properties in these markets based on a 100-point scale. The goal was to determine whether banks and their third-party contractors were equitably maintaining the properties owned.

In three of the four metro areas, properties located in either White or stably integrated neighborhoods were managed substantially better than those in communities of color. In the White or integrated communities, REO properties showed evidence of well-maintained lawns, secured entrances and professional sales marketing. By contrast in communities of color, poorly maintained yard
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The NFHA report also calls for banks, federal regulators, and local governments to take measurable steps to erase the noted disparities.

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EE JOURNEY C2

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Please copy this article for Commissioner Dozier + me
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Enacted four years after the 1964 Civil Rights Act, the Fair Housing Act prohibits discrimination by race in housing sales, rentals, and financing and was signed into law by President Lyndon Baines Johnson. Later in 1988, President Ronald Reagan signed into law the Fair Housing Amendments, which prescribed powers for the Department of Justice along with enforcement penalties and expanded protected classes to include disabilities and familial status.

Yet, despite the passage of time and the enactments, fair housing has yet to reach many Americans of color. The laws may have changed; but discriminatory practices still remain in the housing industry.

The journey towards housing fairness continues.

(Charlene Crowell is the Center for Responsible Lending's communications manager for state policy and outreach. She can be reached at: Charlene.crowell@responsiblelending.org.)

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Just as communities of color were targeted for high-cost subprime mortgage loans, now the high concentration of foreclosed properties in these same communities has led to yet another dilemma: a disproportionate share of neglect among bank-owned foreclosures. Also know as real-estate owned properties, these formerly-occupied homes are bringing blight and contributing to further deterioration of the quality of life in communities of color.

A new report from the National Fair Housing Alliance in Washington, D.C., describes an investigation of 624 bank-owned properties in four markets: Dayton, Ohio; Hartford, Conn.; Maryland's Prince George's County; and Richmond, Va. Field staff visited and evaluated the exterior condition of REO properties in these markets based on a 100-point scale. The goal was to determine whether banks and their third-party contractors were equitably maintaining the properties owned.

In three of the four metro areas, properties located in either White or stably integrated neighborhoods were managed substantially better than those in communities of color. In the White or integrated communities, REO properties showed evidence of well-maintained lawns, secured entrances and professional sales marketing. By contrast in communities of color, poorly maintained yards, unsecured entrances, poor curb appeal and appearances of abandonment were evident.

The report notes that while Prince George's County is a "rare example of a racially and ethnically integrated suburb," its Black neighborhoods, scored well below those of its integrated neighborhoods.

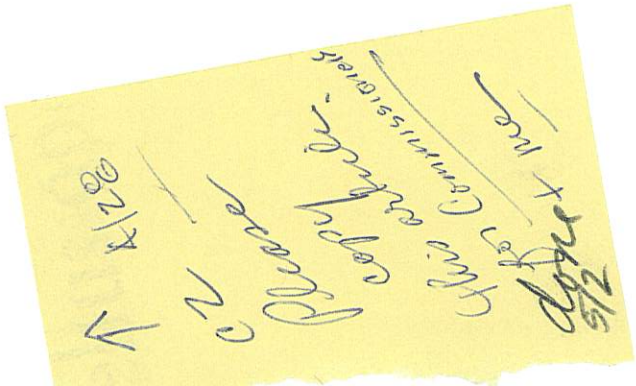
According to NFHA, "A bank risks violating civil rights laws if it owns a home in an African-American or Latino neighborhood and fails to take the same steps to maintain, market, and sell it as it would take for a home in an area with a largely White population."

The NFHA report also calls for banks, federal regulators, and local governments to take measurable steps to erase the noted disparities.

"It is imperative that banks take affirmative steps to maintain, market, and sell all REO properties according to fair housing best practices standards. It is also imperative that federal regulators and enforcement agencies examine the ways in which banks and the vendors that they hire conduct this business" advised NFHA. "Lastly it is imperative that local municipalities and residents remain vigilant and ensure that the concentration of REO properties is not impeding fair housing choices."

The irony is that these findings and recommendations are emerging during the nation's observance of Fair Housing

SEE **JOURNEY** C2



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Month. The month-long observance is intended to commemorate the historic signing of the Fair Housing Act on April 11, 1968.

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