Kidney Transplant Candidates' Views of the Transplant Allocation System

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OBJECTIVES: The point system used to distribute scarce transplantable kidneys places great emphasis on antigen matching. This contributes to increased waiting times for African Americans, who have a disproportionate share of rare antigens. We conducted a pilot study to explore the understanding and attitudes of kidney transplant candidates toward the way the transplant allocation system trades off between antigen matching and waiting time.

MEASUREMENTS AND MAIN RESULTS: We performed semi-structured interviews of a convenience sample of 33 patients awaiting transplants in Philadelphia and its surrounding suburbs. Patients had a number of misconceptions about the transplant allocation system. Many incorrectly thought, for example, that quality of life and financial status influence which patients on the waiting list receive available organs. Despite these and other misconceptions, the majority of patients thought the allocation system was fair. However, many African Americans thought the system was biased against them because of their race. After hearing about how the transplant system factors antigen matching and waiting time into organ allocation, the majority of subjects still felt the system was fair. After hearing that the emphasis on antigen matching causes African Americans to wait twice as long as whites, a larger number of subjects thought the system was unfair. Nevertheless, few thought the system should be changed. Even African American patients who felt the system was unfair still approved of the emphasis on antigen matching out of a desire to have a successful kidney transplant.

CONCLUSIONS: We found that most of the interviewed patients awaiting kidney transplant thought the system should continue to emphasize antigen matching. Although attitudes toward the allocation system differed by race, with African American patients more suspicious of the system, the importance patients placed on antigen matching did not appear to differ by race.

KEY WORDS: kidney transplant allocation; patient attitudes; antigen matching.

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Faced with a shortage of transplantable kidneys, policy makers have been forced to make difficult decisions about who should receive available organs. Presently, kidneys are distributed on the basis of a point system. Kidney transplant candidates are placed on a waiting list and accumulate points on the basis of waiting time, presensitization status, age (if less than 18 years old), and antigenic similarity to the donor.¹ In general, organs are given to the patient in the local area of the donor who has the highest number of points, except when a recipient can be found who is a complete antigen match with the donor.

The point system places great emphasis on antigen matching. Patients can receive a maximum of 10 points

for antigen matching versus only 1 point for each year they have waited for a kidney (plus up to an additional 1 point for the person who has been waiting the longest).¹ Thus, patients with common antigens have a better chance of undergoing transplant than patients with rare ones. This has helped create a situation in which African Americans, who have a disproportionate share of rare antigens, wait twice as long for kidneys as whites.^{2,3} In addition, fewer than 4% of "complete antigen matches" (those kidney transplants in which a donor and recipient match on all six major HLA antigens) go to African Americans.⁴

The point system places great emphasis on antigen matching in order to improve the chance that transplanted kidneys will function without being rejected. Nevertheless, critics have argued that the system places too much emphasis on antigen matching given the small clinical benefits it brings.⁴⁻⁸ One year after transplant, 80% of completely matched kidneys are likely to be functioning compared with 74% of partially matched kidneys.⁵ Defenders of the system argue that because kidneys are scarce everything should be done to increase the chance of transplant success.⁹

In a previous study, we surveyed members of the general public to see what they felt about trade-offs between antigen matching and waiting time equity.¹⁰ We found that a majority of people felt that small differences in transplant outcomes did not justify significant inequities in waiting time, such as those that result from the present system. Although the attitudes of the general public are important, we cannot effectively examine current allocation policies without taking into account the views of the people they affect the most—kidney transplant candidates.

In this article, we report on a pilot study exploring kidney transplant candidates' understanding of and atti-

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tudes toward the transplant allocation system. The pilot study is designed to explore (1) kidney transplant candidates' baseline understanding of and attitudes toward the kidney allocation system; (2) how their attitudes change after receiving information about how antigen matching and waiting time are factored into the system; and (3) how their attitudes change after learning about racial disparities created, in part, by the system's emphasis on antigen matching. We hypothesized that patients, especially African Americans, would not approve of the emphasis on antigen matching after learning about how it influences racial disparities in waiting times.

METHODS

We performed semistructured interviews of a convenience sample of 33 patients awaiting kidney transplants in Philadelphia and its surrounding suburbs. All of the patients were asked the open-ended questions in Table 1. These questions were used to provide structure to the interview and to ensure that the same topics were covered in all interviews, but subjects were permitted to elaborate freely on the issues most important to them. We began the interviews by assessing patients' understanding of the factors used to distribute transplantable kidneys. Next,

we asked subjects whether they thought the system was good or fair. Then we provided subjects with information about how the point system works, as well as how the point system makes trade-offs between antigen matching and waiting time, and asked them how that affected their views of the goodness or fairness of the system. We also examined whether providing patients with information on the racial differences in transplantation waiting time changed their attitudes about the goodness and fairness of the system. Finally, we asked patients if they thought the system would be changed if the system were reversed, that is, if whites waited twice as long as African Americans for transplantable kidneys.

The interviews averaged 45 minutes (range 30 to 70 minutes) and were conducted by the first author. The interviews took place either at the dialysis center when the patient was being dialyzed or over the telephone (nine interviews) when patients could not be contacted at the center. The face-to-face interviews were tape recorded and transcribed for analysis. The telephone interviews were paraphrased at the time of the interview through detailed written notes, and these notes were later transcribed. The transcripts were read by two of the authors, who separately identified common themes and agreed on how to categorize subjects' comments. Disagreements were resolved by discussion between these two authors.

Table 1. Sample Interview Questions

Assessing patients' baseline understanding and attitudes toward the system

- Can you describe the process that you're going through to get a kidney?
- What does it mean that you are on the waiting list?
- What factors determine who gets a kidney?
- What is the point system?
- What do you think of the factors that are used to determine who gets a kidney?
- Do you think this is a good system? Why? Why not?
- Do you think it is fair? Why? Why not?
- Do you think that everyone on the waiting list has an equal chance of getting a kidney?
- If not, who do you think has an advantage?

Assessing the effects of point system information on patients' opinions*

- What do you think of this system?
- Does this sound like a good way to distribute the kidneys?
- Does this sound like a fair system?
- If you could decide how this system works, would you prefer to see more emphasis on matching, waiting time, or would you be somewhere in the middle? Why? Why not?

Assessing the effects of racial information on patients' opinions†

- What do you think of this system?
 - Does this sound like a good way to distribute the kidneys?
 - Does this sound like a fair system?
 - Do you think the system should remain as it stands if this is an end result? Why? Why not?
 - Do you think we should focus on matching if some groups of people get better matched kidneys but other people, like African Americans, wait longer for kidneys?
 - Do you think the current system would be changed if Caucasian patients waited twice as long for transplants as African Americans?
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*These questions were asked after explaining the point system to patients.

†These questions were asked after explaining how antigen matching causes African Americans to wait twice as long for transplants as whites.

RESULTS

Patient demographics are shown in Table 2, which reveals that the majority of subjects were African American, male, unemployed, and on hemodialysis.

Baseline Understanding of the Allocation System

Most patients were aware that matching between donor and recipient, of blood type or HLA antigens, was an important part of the allocation system. For example, 25 specifically mentioned blood type as a major criterion for kidney allocation. Many respondents did not have a firm grasp, however, on how other factors were used to determine transplant allocation. For example, only 6 of 33 mentioned waiting time as a factor in distributing organs.

Patients had a number of misconceptions about the point system. First, 14 patients stated that their quality of life on dialysis would play a role in whether they received a transplant. In reality, once patients are wait-listed for a transplant, there are no distinctions made between them

based on their quality of life on dialysis. Second, 8 patients stated that there was a maximum waiting time such that once they had waited that amount of time they would get the next available transplant. The allotted time was generally thought to be around 2 to 3 years. In reality, the system gives 1 point for each year patients have been waiting for a transplant as well as up to 1 point to the person waiting the longest. Third, 12 patients stated that the waiting list was a set list so that each time someone before them received a transplant they would move up one place on the list. In reality, each time a kidney becomes available, a new list is generated, based on the antigen type of the donor and of patients waiting for kidneys. Thus, one could be near the top of the list with one donor and near the bottom with the next. Fourth, 13 patients stated that financial status was a criterion used to determine whether or not patients received transplants. In reality, money is irrelevant once patients are placed on the transplant waiting list.

Baseline Attitudes Toward the Allocation System

When patients were asked whether they thought the system was a good one, 26 of 33 responded that it was a good system because it focused on saving lives. All of the white patients felt the system was good compared with 12 of 19 African-American patients.

When asked, 20 of 33 patients felt the system was "fair." Eight of 19 African-American patients thought the system was fair, compared with 10 of 11 whites. Of the 11 African-Americans who thought the system was unfair, all attributed the unfairness to race:

It's not fair because of race. They give it to other people first and then they come after black people. I'm wondering what's going on. Did they forget us? (23-year-old African-American woman, waiting 2 months for first transplant)

The fact that I kept seeing more white patients than black patients getting transplants worried me. I didn't know if people were getting preferential treatment. But I guess the part that scared me the most was that I looked around and all I saw was black patients and only one or two white people in the unit. They'd be here for a short period of time and then they'd be gone. (36-year-old African-American man, waiting 4 years for second transplant)

Only one white patient thought the system was unfair, attributing the unfairness to the supposed role that financial status plays in transplant allocation.

When asked, only 11 of 33 patients felt that everyone on the transplant list has an equal chance of getting a transplant. While 7 of 11 whites felt that everyone has an equal chance, only 2 of 19 African Americans thought so. Patients who did not think that everyone has a fair chance cited celebrity status, money, and race (African Americans only) as the key advantages that some people have over others. Seven of 14 whites stated that all patients have an equal chance of getting a transplant, except for celebrities, who receive special priority. In con-

Table 2. Patient Demographics

Characteristic	Number
Race, <i>n</i>	
African American	19
Native American	1
Asian	1
Latino	1
White	11
Age, years	
Range	22–56
Mean	40
Gender, <i>n</i>	
Female	15 (45%)
Male	18 (55%)
Education, years	
Range	10–19
Mean	13
Time on list	
Range	2 wk–8 yr
Mean	17 mo
Number of previous transplants, <i>n</i>	
0	19
1	11
2	2
3	1
Type of Dialysis, <i>n</i>	
Hemodialysis	25
Evening exchanger	3
Peritoneal	5
Employment status, <i>n</i>	
Unemployed	22
Full-time employed	8
Retired	2
Student	1

trast, 17 of 19 African Americans stated that even among noncelebrities, white patients still have an advantage.

The Effect of Point System Information on Patient Attitudes

After explaining the way antigen matching and waiting time are factored into the point system, we asked patients if they thought the system was good and fair and whether they would like to change it. Of 33 patients, 25 felt that the system's emphasis on antigen matching was good. Thirteen of 19 African Americans held this view, compared with 10 of 11 whites:

I wouldn't want them to give me that kidney because they think I've been waiting a long time. I want them to give me that kidney because it's the closest match they've seen for me. (34-year-old African-American woman, waiting 8 years for second transplant)

If we don't get the best match it's not good to put it in the body. If the spices aren't right then the pot won't cook, right? (31-year-old Latino woman, waiting 1 year for second transplant)

In contrast, 12 patients (8 African Americans and 4 non-African Americans) thought that there should be more emphasis on waiting time and less on antigen matching.

A common theme among white patients was that because their quality of life was minimally affected by dialysis, they did not feel the need to increase the emphasis on waiting time:

I think that life expectancy is much more important than waiting time. I'd rather wait, but then again I think that's because I'm doing well on dialysis. Maybe I'd feel differently if I wasn't doing well. But I am, so I'd rather wait for a better kidney. (34-year-old white man, waiting 2 years for first transplant)

I guess when you hear the explanation you would be more willing to take a little risk and not have as good a match 'cause it would mean you'd get the transplant sooner . . . but I don't think that way because I feel healthy now. (37-year-old white woman, waiting 7 years for second transplant)

Ten patients stated they did not want to decrease the emphasis on antigen matching because they were afraid of transplant rejection. This fear was particularly common among those who had experienced rejection to previous transplants:

I trust the system enough to wait as long as it will take to increase my chance of survival. I don't want to go through rejection even if there is no guarantee that I won't. I don't want to take my chances so I'll wait as long as it takes. I'd be discouraged but I'll have to deal with it. (40-year-old Native American man, waiting 3 years for second transplant)

I think matching is the most important factor. I know some people would rather take the less-matched kidney sooner but rejection is bad news. I've been through it. I'd rather wait and have it work longer. I'm doing all right so I can say that. I think dialysis is better than the alterna-

tive . . . death. (50-year-old white man, waiting 1.5 years for second transplant)

The Effect of Racial Information on Patient Attitudes

After explaining that the emphasis on antigen matching is part of the reason African Americans wait twice as long as whites, we asked patients if this changed their opinions of the allocation system. Before receiving this information, 26 of 33 patients thought the system was good. After receiving this information, only 17 of 33 patients still thought the system was good. Those who now criticized the matching system (7 of 19 African Americans and 2 of 11 whites) stated that the difference between a 70% and 80% success rate was not enough to justify inequitable waiting times.

Nevertheless, among those who now criticized the system, few thought it should be changed. Two white men who felt the system should not be changed stated:

I still like the matching. I know this sounds mean, and I don't mean to, but that is the way the cookie crumbles. It doesn't sound like this happens because they are black. We are all different. It's like peas and carrots. If it was a racial question, then I'd change my answer, but it's a medical issue. (23-year-old white man, waiting 9 months for fourth transplant)

I just don't think it's a matter of prejudice. I want the best match and I'm sure that black people probably do, too. I'm looking at this medically, and this is the best way to do this. (40-year-old white man, waiting 2 years for first transplant)

The following responses are representative of statements made by African Americans who thought the system should not be changed:

I would still go with the matching because even though 10% is not a big difference, I'd still rather have a kidney that matches better than to get one because I've waited so long. (36-year-old African American woman, waiting 3 years for first transplant)

I'd rather wait and hope my chances are better . . . I don't look at it as making us wait longer. I mean, if the shoe doesn't fit . . . you going to squeeze your foot in there anyway? (25-year-old African-American man, waiting 5 years for second transplant)

When asked whether they believed that officials would change the system if the situation were reversed, such that whites waited twice as long for kidneys as African Americans, 6 of 11 white patients said the system would not change:

I think it would stay like it is. I truly think science is blind. It is not racial. (40-year-old white man, waiting 2 years for first transplant)

Four of 11 whites, however, said that the system would be changed if antigen matching favored African Americans:

I hate to admit it, but I think the system would change. We have more power in today's society so it would

change. (23-year-old white man, waiting 9 months for fourth transplant)

Thirteen of 19 African Americans agreed that the system would be changed if the situation were reversed:

You know that! That's right! You think that white folks would be waiting so long, not wanting to change the system? That's how it's hooked up! You know they'd be raising holy hell! That's right. They would change it! (53-year-old African American man, waiting 3 months for first transplant)

It would change. Definitely. Right away. The world is for the white population. They want them saved as soon as possible. Prime examples are Governor Casey and Mickey Mantle. Nobody black could have that except maybe Johnny Cochran or Michael Jackson. Nobody other than that. (36-year-old African-American female, waiting 3 years for first transplant)

Thirteen of these 19 African American patients, despite saying that officials would change the system if whites had to wait longer for transplants, still said that they would not change the present system in order to decrease inequities that they as African Americans face. This seeming contradiction is captured by the following patient:

We're in America; it has always been racial. They would take our [kidneys] in a minute. We know that. It's always been like that. That is the unspoken part that we understand. If you continue to do that on either side then you are no different. I'm saying it should not happen that way. And I am not going to advocate that at any level. (48-year-old African-American man, waiting 4 years for first transplant)

DISCUSSION

In this preliminary study we had three main objectives. First, we wanted to assess kidney transplant candidates' attitudes toward and understanding of the kidney allocation system. Second, we wanted to assess how their attitudes toward the system would change once they were given information about how antigen matching and waiting time are factored into the allocation system. Third, we wanted to see how their attitudes would change when they learned about the racial disparities created, in part, by the system's emphasis on antigen matching.

We found that kidney transplant candidates have several misconceptions about the system, with many thinking that race, celebrity status, and financial status influence the allocation of organs among those on the waiting list. Despite these misconceptions, patients were generally satisfied with the system.

We were struck by how receptive patients were to discussing the kidney transplant allocation system. For many, it was the first time they said they had been exposed to these issues. At the conclusion of the interviews, many asked for further information about how antigen matching influences transplant success. We think this shows that, if given an opportunity, patients will be ex-

tremely eager to participate in and contribute to dialogues about how to balance antigen matching and waiting time. We also think this highlights a need for further efforts to educate patients about the allocation system.

Before this study, we thought that kidney transplant candidates, much like members of the general public,¹⁰ would think that the system places too much emphasis on antigen matching and not enough on waiting time. We were surprised to find the opposite. Even after providing patients with detailed information about the allocation system, we found that most thought the system should continue to emphasize antigen matching and were reluctant to change it in any way.

Although most patients agreed that the system should continue to emphasize antigen matching, we found that patients' reasons for holding this opinion differed according to race. White patients were more trusting of the system and of doctors in general, and thus were less willing to entertain different approaches to kidney allocation. Conversely, African American patients were more suspicious of the system. They showed less surprise on learning that African Americans wait longer for kidney transplants than whites. They also seemed more willing to admit that race can play a role in transplant allocation. Nevertheless, some African Americans were resigned to the fact that they could do little to change the system to benefit African Americans. Thus, their unwillingness to change the system may have resulted less from a sense that they trusted the system than from a sense that this was the best they could expect from the system.

It is worth speculating on why transplant candidates were more in favor of antigen matching than were members of the general public in our previous study. One possibility has to do with their relative familiarity with the consequences of going through transplant rejection because of a poorly matched kidney. Some of the transplant candidates interviewed in this study had already undergone rejection and were understandably reluctant to go through it again. Many of the patients waiting for their first transplants may have met other patients in dialysis units who had had a failed transplant and, thus, may have been more worried about the risks of rejection than the general public would be.

Another explanation for the difference between transplant candidates' views and those of the general public may have to do with whether the trade-off between antigen matching and waiting time is framed as one that affects individuals or groups. In our survey of the general public, subjects were asked to think about how emphasis on antigen matching affects groups of transplant candidates.¹⁰ In the present study, although subjects received information about how antigen matching affects groups, they may have thought primarily about how this would affect themselves as individuals. Research has shown that people are sensitive to whether trade-offs are framed in terms of how they affect individuals or groups.¹¹ Indeed, in a study of attitudes toward retransplantation, we

found that subjects were more inclined to favor efficiency over equity when the issue was framed in terms of individuals receiving transplants rather than groups.¹²

This study has a number of limitations. First, our findings are limited by the nonrepresentative nature of our study population. Second, nine of our interviews were conducted over the telephone, which changed the dynamics of the interviews as these patients were unaware of the race of the interviewer. In addition, those subjects interviewed in the dialysis center may have responded differently in other settings.

Third, all our interviews were conducted by the first author, an African-American female, making it impossible to know how her gender and race influenced subjects' responses. Fourth, the interviewer was not blind to our study hypothesis that patients would not approve of the emphasis on antigen matching after learning about how it influences racial disparities in transplant allocation. However, we anticipated that, to the extent that the interviewer's race and knowledge of the study hypothesis influenced subjects' responses, it would cause subjects (especially African Americans) to express greater displeasure with racial disparities and transplant allocation. Rather, subjects were highly supportive of the present allocation system. Nevertheless, future studies ought to involve interviewers of different racial and gender groups who are blinded to the study hypotheses.

Fifth, in the interviews we exaggerated the benefit of antigen matching, stating it improved transplant outcomes from 70% to 80% rather than from 74%. We thought these success rates were easier to explain to subjects (in fact, we talked about 7 out of 10 successful transplants in a year versus 8 out of 10), having discovered in pretesting that many subjects had difficulty understanding percentages. We also exaggerated the benefits of antigen matching because, in advance, we had thought that subjects would place great emphasis on equitable waiting times, and, therefore, wanted to round the numbers in a way that favored antigen matching. Subjects may have expressed more displeasure with the system's emphasis on antigen matching if we had not exaggerated its benefit.

Sixth, subjects' responses may have been influenced by order effects. All were asked first what they thought at baseline about the transplant allocation system, then were given successively more detailed information about antigen matching, waiting time, and racial equity. Having stated at the outset that they thought the system was good and fair, many may have been unwilling to change their minds. If, instead, the interview had begun with a detailed explanation of the allocation system, subjects may have been more likely to state that they were displeased with it.

Despite these significant limitations, this pilot study offers useful data to guide future research in this important area. Our study suggests that, despite worries about racial bias in the present transplant allocation system,

transplant candidates (including African Americans) do not disapprove of it. We had thought initially that any mention of how antigen matching influenced waiting time by race would make African-American transplant candidates disapprove of the system. This was not confirmed by this pilot study. In addition, we were surprised at the importance patients placed on a relatively small difference in transplant outcome, between 70% one-year graft survival and 80%. This suggests that patients will go to significant lengths to improve their chance of a successful kidney transplant. It also suggests that future work in this area should explore patients' attitudes toward smaller improvements in transplant outcome.

This qualitative study is the first we know of to assess the attitudes of kidney transplant candidates toward the allocation system. Although only scratching the surface of this important topic, our study suggests that patients want to discuss these issues and that their opinions may differ from those of policy experts and of the general public. Our study suggests that, even among those who would seemingly be most inclined to criticize the system, African Americans, most find the system acceptable. Nevertheless, future studies should be undertaken with representatively selected patients to find out whether the trade-off between antigen matching and waiting time built into the present allocation system corresponds to the trade-off patients would choose to make.

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REFERENCES

1. United Network for Organ Sharing (UNOS). Articles of Incorporation. UNOS, Richmond, Va; 1995.
2. Kusserow RP. The Distribution of Organs for Transplantation: Expectations and Practices. Washington, DC: Office of Inspector General, Department of Health and Human Services; 1991.
3. Ayres I, Dooley LG, Gaston RS. Unequal racial access to kidney transplantation. *Vanderbilt Law Rev.* 1993;46:805-63.
4. Gaston R, Ayres I, Dooley LG, Diethelm AG. Racial equity in renal transplantation: the disparate impact of HLA-based allocation. *JAMA.* 1993;270:1352-6.
5. Held PJ, Kahan BD, Hunsicker LG, et al. The impact of HLA mismatches on the survival of first cadaveric kidney transplants. *N Engl J Med.* 1994;331:765-70.
6. Yuan Y, Gafni A, Russel JD, Ludwin D. Development of a central matching system for the allocation of cadaveric kidneys: a simulation of clinical effectiveness versus equity. *Med Decis Making.* 1994;14:124-36.
7. Wujciak T, Opelz G. A proposal for improved cadaver kidney allocation. *Transplantation.* 1993;56:1513-7.
8. Lazda VA. An evaluation of a local variance of the United Network for Organ Sharing (UNOS) point system on the distribution of cadaver kidneys to waiting minority recipients. *Transplant Proc.* 1991;23:901-2.
9. Takemoto S, Terasaki PI, Gjertson DW, Cecka JM. Equitable allocation of HLA-compatible kidneys for local pools and for minorities. *N Engl J Med.* 1994;331:760-4.
10. Ubel P, DeKay M, Baron J, Asch D. Public preferences for effi-

- ciency and racial equity in kidney transplant allocation decisions. *Transplant Proc.* 1996;28:2975-80.
11. Redelmeier DA, Tversky A. Discrepancy between medical decisions for individual patients and for groups. *N Engl J Med.* 1990; 322:1162-4.
12. Ubel PA, Loewenstein G. The efficacy and equity of retransplantation: an experimental survey of public attitudes. *Health Policy.* 1995;34:145-51.

REFLECTIONS

Ave Regina

I bleed easily and my tears
rain on her porcelain skin.
Her tongue hangs perpetually
outside an apologetic mouth
under slanted eyes
a child forever
burdened with one more
chromosome:
stranger angel
harboring volumes of water's mystery
kith and kin to sacred things
her movements awkward
except when music sounds and she dances
or sings
the force of her subdued passion
the beauty in her China eyes
on her chapped lips
a smile never wanes. I love her lightness
her smile,
through Moon-width teeth
not quite straight,
stutters a cathedral in her throat.
She cries next to nothing.
Except
her neck is always lowered
as if on the ground
she seeks the lodestar
of her original sin.

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