

End-of-life care and organ and tissue donation in South Africa – it's time for a national policy to lead the way

To the Editor: We refer to the guest editorial in the July SAMJ,^[1] which appealed for a national policy to optimise organ donation. The authors highlighted a concerning 'sense of uncertainty regarding the roles of healthcare professionals in the end-of-life care of terminal patients and procurement of organs from deceased donors'. They also identified the alarming cost to a system that relies on dialysis in the setting of a kidney transplant rate of only 4.1 per million population, and call on the government to create a more effective organ donation policy via so-called 'national self-sufficiency'. We applaud the authors for promoting improved education for nurses to increase the rates of organ donation in South Africa (SA).

Nevertheless, the South African Burn Society was disappointed to note that tissue donation, and specifically donation of skin, was not mentioned, despite the fact that 'organs and tissue' should always be introduced together when permission is sought for deceased donation.

While organ transplantation and burn surgery are regarded as advanced, centralised subspecialties internationally, only organ transplantation has truly been afforded that status in SA. Burn surgery continues to be poorly resourced and under-staffed despite the extremely high incidence of burn injuries in this country, and there appears to be little desire to improve the situation. Every year more than 3.2 per 1 000 South Africans sustain burn injuries requiring medical attention, and a considerable proportion of these patients are young and/or economically active at the time of their burn.

While many refer to SA's healthcare service as crippling under-resourced, there is no doubt that poor resource allocation is also responsible, evident from the perspective of burn services by the fact that other surgical specialties, for example, benefit from considerably more operating time, staffing at all levels, surgical instrumentation and beds in tertiary facilities relative to clinical demand. Misconceptions of the complex interdisciplinary resources required to optimise burn care and outcomes persist. For example, where burn centres do not have their own intensive care facilities, many state-funded intensive care units in SA continue to enforce a policy of denying access to patients with burn injuries, owing to perceived poor outcomes and misplaced concerns about infection prevention and control.

It is well recognised that deceased donor allograft is a fundamental resource for the burn surgeon to improve the standard of care of patients with major burn injuries.^[2-5] Cadaver skin, when available, has been shown to reduce both mortality and morbidity, and can contribute to reductions in hospital stays and successful societal reintegration. This relies on ready access via skin procurement, processing, banking and distribution. SA has recently established such a skin bank,^[4] but cadaver skin continues to be in extremely short supply, ostensibly owing to the absence of a tissue donation culture.

The South African Burn Society strongly appeals to the organ donor community to assist us to incorporate discussion about tissue donation, and especially skin, on organ donation platforms, and desist from focusing just on organs, when opportunities such as this arise. We support the authors in motivating for a national policy to

improve organ donation, on condition that tissue donation is also part of such a policy.

The authors write on behalf of the Executive Committee of the South African Burn Society.

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