https://doi.org/10.52645/MJHS.2026.1

UDC: 616-089.843:614.2(560+519.5)

LETTER TO THE EDITOR

Leadership in living organ transplantation: beyond deceased donor shortages in Turkey and South Korea

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Dear Editor,

Turkey and South Korea rank among the countries with the highest rates of living donor organ transplantation, particularly kidney and liver transplants, worldwide [1]. This phenomenon is often attributed solely to the scarcity of deceased donor organs. However, current data and the literature suggest that this pattern arises from a more complex, multi-layered, and structural set of factors [2]. In this letter, I aim to discuss the common dynamics underlying this leadership.

According to The Transplantation Society, the rate of deceased donors in Turkey and South Korea is approximately 7–8 per million population, which is markedly lower than that in many Western European countries [1]. Nevertheless, both countries have developed robust living donor transplant systems and have achieved substantially high transplant volumes.

Firstly, strong family ties and collectivist cultural frameworks facilitate societal acceptance of living donation in both countries. Norms of intra-family altruism, moral responsibility, and caregiving encourage a perspective that prioritizes family welfare over individual autonomy. This socio-cultural context frames the decision to become a living donor not merely as an individual choice but also as a moral duty [3-5].

Secondly, the legal and institutional infrastructure in both countries supports living donor transplantation. In Turkey, Law No. 2238 and the subsequently developed national coordination system facilitate living donor programs; in South Korea, living donor transplantation legislation enables relatively fast and accessible donation processes [6, 7]. In contrast, deceased donor systems remain limited due to challenges in brain death diagnosis, intensive care infrastructure, and reporting chains.

Thirdly, high surgical and academic expertise constitutes a crucial common factor. Both countries host high-volume transplant centers, experienced surgical teams, and advanced techniques, particularly in living donor liver transplantation. This ensures acceptable risk profiles for both patients and donors and encourages clinicians to more frequently recommend living donation [8, 9].

Fourth, and often overlooked, is the differential perception of ethics compared to Western countries. While Western bioethics centers on individual autonomy, relational autonomy and family-centered decision-making predominate in Turkey and South Korea. Consequently, the ethical boundaries of living donation may be interpreted more broadly [10, 11].

In conclusion, the leadership of Turkey and South Korea in living organ transplantation cannot be explained solely by deceased donor shortages. This phenomenon emerges at the intersection of cultural norms, legal frameworks, healthcare system organization, academic surgical capacity, and ethical paradigms. Therefore, when evaluating "success" in international comparisons, the ethical, societal, and systemic costs of high living donor rates should also be considered.

I hope this discussion contributes to the ongoing international academic dialogue on transplantation policies and ethical frameworks.

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Manuscript received: 25.12.2025

Accepted for publication: 14.02.2026

Published: 15.03.2026

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