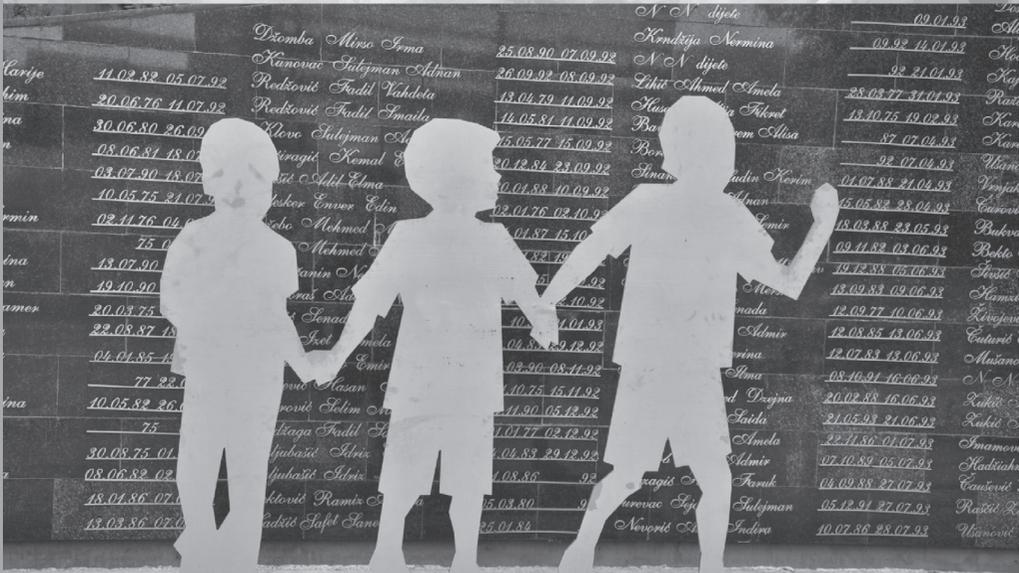




TOBB ETÜ | Medicine
University of Economics & Technology

“RETHINKING MEDICAL ETHICS DURING WARTIMES AND CRISES:

AN INTERDISCIPLINARY WORKSHOP IN THE WAKE OF THE BOSNIAN WAR”



November 19,
2025

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Economics and Technology Faculty
of Medicine Additional
Classrooms Building Grand Hall

13:00

Panel and Workshop Moderated by:

Prof. Dr. P. Elif Ekmekci

Assist. Prof. Başak Akar Özer



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IN THE WAKE OF THE BOSNIAN WAR

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Prof. Dr. P. Elif Ekmekci MD
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November 19, 2025

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Emina Zoletic

Tuna Göktürk

Foreword

The book you're holding offers both an academic perspective and an ethical stance.

In 1991, following the death of Yugoslav President Tito, rising nationalist movements led the Balkans away from peace toward a deep division. This fragmentation, fueled by paramilitary forces and the seizure of political and military power, plunged the region into one of the bloodiest wars in modern history. The military clashes not only drenched the land in blood but also claimed thousands of civilian lives in inhumane ways, leaving many injured and countless souls scarred forever. Time seemed to stop on July 11, 1995, in Srebrenica, when 8,372 people were brutally murdered in the heart of Europe—under the eyes of the international community and the media—in what became one of the most horrific genocides of our era. Today, on the 30th anniversary of the Srebrenica Genocide, as mass graves continue to be uncovered and identities painstakingly verified, families of the victims and younger generations remain determined in their pursuit of justice.

In the 30th year of the Srebrenica Genocide, we aim to bring a rarely addressed topic “**Medical Ethics in Times of War and Crisis**” as a quest for justice into focus and reflect on the lessons learned from war through an interdisciplinary lens centered on the Bosnian conflict. We emphasize that the Bosnian War is not merely a historical event—it is an unresolved wound. With this in mind, we invite discussion on how future medical doctors can uphold their responsibilities during war and crisis, how the commitment to human dignity can be sustained, through the interconnected fields of medicine, political science, international relations, and mental health.

The idea of “Medical Ethics in Times of War and Crisis: An Interdisciplinary Workshop on the Bosnian War,” as an event was born and made real through the collaboration of TOBB ETÜ University, Ankara Yıldırım Beyazıt University, and the Bosniak Studies Initiative, with contributions from the TOBB ETÜ International Bioethics Student Community. On November 19, 2025, the workshop was held at the TOBB ETÜ University, honored by the presence of Prof. Dr. Yusuf Sarınoy, Rector of TOBB ETÜ. The workshop aimed to highlight the ethical dilemmas faced by physicians in times of war and crisis, while also revisiting the historical and political legacy of the

Bosnian War. In the foyer area, attendees were welcomed by an exhibition featuring photographs by Prof. Dr. Nejat Akar and Prof. Dr. J. Sedef Göçmen, which reflected the ongoing impact and traces of the Bosnian War in contemporary spaces.

In the first session of the workshop, Dr. Fatima Dautbasic-Klempic, who served during the Bosnian War, shared her experiences of practicing medicine under wartime conditions with aspiring young physicians. Following this, the political dimension of medical practice during the Bosnian War, the status of healthcare professionals within the framework of international agreements, and the ethical responsibilities assumed by doctors and researchers in the post-war period were discussed by Prof. Dr. P. Elif Ekmekci, Assist. Prof. Dr. Başak Akar Özer, Assist. Prof. Dr. Adisa Avdic Küsmüş, and Dr. Emina Zoletic. Consequently, the Bosnian War was examined through an interdisciplinary perspective, encompassing medical ethics, political science, international relations, sociology and mental health perspectives.

In the interactive second session, in a question and answer format, doctors and experts explored the boundaries, responsibilities, and practical challenges of medical ethics in the face of potential crises or war. The discussions were enriched by Tuna Göktürk's presentation on the experiences of Bosniaks after the war, Prof. Ekmekci's insights on data sharing and ethics during times of crisis, and the introduction of Dr. Sercan Kürklü's book, *Disaster Ethics*. During the session, survivors of the genocide and aspiring physicians posed their questions to the presenters, and possible ethical dilemmas were discussed. The readers of this book will find the key take aways from the discussion session.

The fact that the discussions and the traces of the Bosnian War continue to serve as a lesson while so many atrocities and wars persist around the world today inspired us to turn the presentations and discussion notes from this workshop into a book. Encountering such a supportive academic environment and partnership was truly our good fortune, both in planning and carrying out the workshop and in the process of preparing this book. In this regard, we would first like to express our gratitude to Prof. Dr. Yusuf Sarımay, Rector of TOBBETÜ University, for making this opportunity possible for us. There were also many invisible contributors throughout this process, and making their efforts visible is very meaningful to us. The Bosniak Studies Initiative played a key role in providing resources and communication. The

TOBB International Bioethics Student Community followed the meetings and discussions with remarkable dedication, far beyond what one would expect from a student association, they worked tirelessly to ensure the technical process and flow run smoothly. Özlem Çanakçı, who designed the workshop's posters, brochures, and flyers, approached this task with heartfelt ownership rather than seeing it as just a job, and created truly special visuals. Belkıs Karaçayır, Çiçek Çuhadar, and Nuray Esim held the invisible threads of coordination between the faculties and the university. The staff of TOBB ETÜ worked with great courtesy during the event, in the foyer, and in service, ensuring the workshop ran seamlessly.

The book you are holding, "Medical Ethics in Times of War and Crisis: An Interdisciplinary Workshop on the Bosnian War," consists of three main sections. The first section includes the full academic texts of the presentations delivered during the opening panel of the workshop. The second section features the discussions from the workshop's closed and interactive session, the full texts of the presentations, and notes from the question and answer segment. We cannot thank enough all the language editors, reviewers, and authors who contributed to the preparation of this book. Dr. Mirsad Krijestorac provided invaluable feedback, suggestions, and peer review, while Mena Krijestorac, through voluntary language editing, made it possible for this book to be published in English and accessible internationally. We hope this book finds its way to many readers and serves its purpose well.

Assist. Prof. Başak Akar Özer

Ankara Yıldırım Beyazıt University

Department of Political Science and Public Administration

Introduction

This book is a short expression of the event on “Rethinking Medical Ethics During War Times and Crises: An Interdisciplinary Workshop in the Wake of the Bosnian War”, held at TOBB ETÜ School of Medicine on 19 November 2025. This was a hybrid event, having attendees from medical students, medical and international relations scholars, experts, and war victims.

This workshop was an initial step for medical school students to comprehend the moral extent of their profession in times of conflict, war, or crises. The moral responsibilities of healthcare staff, mainly physicians, under these unexpected circumstances are complex and full of ethical dilemmas. The complexity of this task lies in the responsibilities of physicians to help and cure humans while dealing with a deep pain, the urgency to protect their own and their loved one’s lives and while doing so being loyal to core values of the medical profession.

While we were preparing for this workshop, I heard a common expression from many of the people we contacted: “We were not ready for this. No one taught us how to deal with these difficult issues, morally and emotionally”. This was a phrase we witnessed from healthcare staff during the COVID-19 pandemic. I recall clearly how physicians suffered to address the needs of many patients, when they lacked sufficient resources to do so, and how they struggled to protect their well-being while trying to do their best for their patients. We know that several numbers of healthcare staff lost their lives in this struggle. We witnessed similar outcries during the latest earthquake we had in Türkiye in 2023 which led to at least 50 thousand casualties. Recent years we witnessed millions of people who had to flee from their countries in search of a safe place for their families. Unfortunately, we are living in a geography, on which crises, wars, conflicts or migration of fluxes have never ended throughout history. That is why it is our duty to pass our experiences to next generations to equip them to deal with these difficult situations.

What we talked about in this workshop was not something that happened “*in the past bad bad days, when bad people did horrible things to humans*”. On the contrary, what we talked about the Bosnian War has been, and is, a reality for millions of people on the world today. Names change, countries change, but pain, suffering and conflict sustain.

So, please, when you are reading this book, make your conscience awake. Ask yourself what the morally right thing would be to do when performing your profession under such pressure, a pressure that is amplified by losing your loved ones, the risk of death or being subject to inhumane treatment. The question is “how we can set our moral compass as a medical professional?”

Although it is a difficult task to keep our moral compass, I have two hints that might help you. First avoid this approach: “If I don’t do it someone else will.” This is the toxic approach that erases your moral agency and creates the illusion that your actions don’t matter. The second one is; “If circumstances were ideal, I would do morally right thing”. This approach implies that crises are not the time for morality, but survival, and we are not responsible for our morality when we have such huge threats in our lives, which is a total fallacy.

Let me refer to Frankl in *Man’s Search for Meaning* that speaks directly to moral responsibility—especially in the darkest, most violent periods of history: Circumstances can strip away almost everything, but they cannot remove a person’s responsibility to choose decency over cruelty: **war doesn’t erase moral duty—it intensifies it.**

I am not sure if any class can prepare young medical students for such difficult situations, but still I felt the urgency to do something, to at least give them a chance to reflect on these issues before they graduate. That is why we held this workshop.

I sincerely thank Dr. Başak A. Özer for the enormous effort she put in this event and the members of TOBB ETÜ International Chair in Bioethics World Medical Association Cooperation Center Student Association for their collaborative work.

Prof. Dr. Perihan Elif Ekmekci

TOBB ETÜ School of Medicine

Department of History of Medicine and Ethics Chair

Medicine and medical ethics started the very day a person heard another person's cry for help and decided to offer a helping hand. Thus, it is the area where human connection and vulnerability are at the forefront of practice. This already fragile state is held to trail especially during crisis situations. Medical ethics in wartime is one of the areas where both the scientific and human foundations of medicine are most severely tested. As laid out by the World Medical Association's International Code of Medical Ethics, we as physicians are not only responsible for our patients as individuals but for the health and well-being of the population as a whole, including future generations.

This workshop gave us the opportunity to discuss the impartiality of healthcare in conflict environments, the limits of physician responsibility, and the practical implications of international ethical norms. Invaluable insights shared by our guests once again highlight the need for specialized codes of conduct for healthcare workers operating during wartime and genocide. On behalf of the TOBB ETÜ International Chair in Bioethics/WMA Cooperation Center Student Association, I am fortunate to be part of this discussion and to help those who have experienced this tragedy share their experiences. Their brave and empathetic stand will forever set an example for our future practices.

Zeynep Sare Kırbaş

Head of the TOBB ETÜ International Chair in Bioethics / WMA
Cooperation Center Student Association

MEDICAL DOCTORS AND POWER POLITICS IN THE BOSNIAN WAR: IN-BETWEEN DEHUMANIZATION AND ETHICS?

Assist. Prof. Başak Akar Özer

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We are here to discuss the place, roles, and the responsibilities of the doctors during wartime and crises, as well as to deduce some lessons from Bosnian War. However, I would like to start speaking by reminding an important point. Bosnian War is not just history. It is a human tragedy seeking closure. Bosnian War is an ongoing political and judicial debate, which is unresolved, especially in the light of recent Italian and US legal cases related to “Human Safaris during the Siege of Sarajevo”, where prosecutors have pressed charges on the basis of dehumanization. It seems we will keep discussing the term dehumanization of the human beings and the levels of it, in the context of Bosnian War for a very long time.

I kept a copy of one of my assignments about Nazi genocide from my college years to look at every now and then to remind myself how a human perseveres under hopeless conditions. The books from Primo Levi, which I cited there: *If This is A Man* Truce, *The Drowned and the Survived* (Levi, 2023a; 2023b), shaped how I understand and question dehumanization today. Both books and the assignment have had a significant impact in shaping my personal worldview at a young age and my academic perspectives. After reading Levi’s books, I could capture how his life was changed irreversibly because of the dehumanization and aggression he and his inmates in the camp had to endure. What was interesting within that assignment is that in it, I also quote one of his sentences focusing on how powerful the desire for life within us is, even under times of pressure. He says, the belief regarding preservation and the meaning of life has been rooted throughout the cells of the human flesh and it is a part of human nature. This part of human nature as the core would claim the human dignity back as a right. From his writing, we know much about the meaning he and his inmates were chasing

to survive in the camps, and we see this desire to move on which led to many of their strategies for survival. How would the survivors respond to dehumanization? Dehumanization, as Stanton (2008) argues, encompasses othering practices, and constitutes a crucial step towards genocide.

The experience of Nazism has generally been defined as a unique case to have the medical professionals have agencies and roles to medicalize every inch of life. However, one should also think about the other historical and cultural conditions paving the way for diversified power dynamics that eventually shaped general strategies of the political power and the agency, as well as counter-tactics of subjects (Foucault in Chatterjee, 1987, p.348-349). We can ask, "Would there still be a political "agency of death" if a direct brutality is not demonstrated by the doctor?" (Tiefenbrun, 1999, p.135). Those same ideas that made me question the relationship between biological life and politics, encouraged me to think more profoundly about the agency of the medical doctors in times of political unrest. Of course, both ethics and political science literature gathered important and significant empirical data from Nazi experience. However, scholars usually tend to distance themselves from the subjectivity of the oppressed individuals who had to witness and experience the aggression in the first place. Instead, they tend to only observe the causes of such things happening through top-down policies causing a crisis of humanism, as if the actions of the agent and the voices of the subject are not part of the political realm. Indeed, such a perspective reflects specific institutional arrangements. The Nuremberg trials were conducted according to the notion of association, where the involvement of the doctors in wars with crimes against humanity was considered individual criminality (Tiefenbrun, 1999, s.126). At this point, we would leave the problem of the aggression, including the doctors who survived or the doctors who perpetrated crimes, and use their words as a foundation to build either empathy, sympathy or condemnation. But today, we have begun to consider that subjectivities may also help explain genocides. Hearing and acknowledging the silenced can be a powerful tool to deflect the existing power dynamics away from darkest objectives and circumstances. A prominent example of this turn is Victor Frankl's, a neurologist and a psychiatrist, with his autobiographical notes. So, the doctors of the Holocaust were not only the ones working for excessive forms of eugenics, but also the ones who became sounds of the victims and remedies of the survivors. "Never again," the slogan that came out of the Holocaust, obviously did not work, and we have come to witness many other

instances of mass violences, genocides and atrocities, and some that are ongoing in Myanmar, Palestine and other parts of the world.

A survivor's notes on the Bosnian War; psychiatrist Dr. Esad Boškalić's memoirs (Lieblich and Boskalo, 2012) open a space to break the silence for both the wounded and the healer, from one of the worst human tragedies that took place in Europe at the end of the 20th century. The aggression of the Bosnian War and the Srebrenica Genocide are particularly important to be elaborated on, as the chain of events that triggered that carnage was politically and ideologically fostered, with culture and power politics at its core. Furthermore, the genocide in Bosnia has been the most brutal aggression since World War Two, in a continent which had so often been viewed as the embodiment of the peace with its institutions. The brutal events took place before the international community, not only through media channels but also in front of the eyes of the United Nation's officials and soldiers. The cultural factors and politics behind it, were scrutinized in the literature and found to be the best way to explain how events were propagated ideologically (Becirevic, 2014). However, there is not much written work on the role of medical practice.

With that, there is another point to highlight: the position of the medical doctors during the times of war and how the agency of the medical doctors was in such situations. Doctors played a significant role during the Bosnian War not only in terms of serving the patients' needs, but also upholding their ethical stance while, at the same time, fighting for their own lives. On the other hand, there was a group of medical doctors who chose not to follow the oath that they took and worked for the interests of a particular ethnic group and their political agenda. I would refer to this group of doctors as the doctors of the "others", although I acknowledge that it is not possible to categorize medical doctors according to their ethical stances.

Thus, this distinction should not be understood as a normative classification of medical doctors as ethical or unethical, or simply good or bad, but as an analytical division to observe their politically situated positions within relations of power. Much of the biopolitics literature from political theory deals with the problem of power politics over bodies and life; often framing medicine as a site of political practice that governs life and death, rather than a purely technical field (Foucault, 2008). Despite the criticism of biopolitics literature for its correlation tendencies, scholars in the field have dedicated effort to explore how bodies can be spaces for meanings, agents

for power dynamics and transmitters of political power (Alsheh, 2017; Horigan, 2021). Yet, there is still a lack of consensus on how the subjectivity, and the agency should be elaborated within the context of power dynamics. However, the scholars developed a perspective to question the transforming relationship between medicine and politics by looking at the consequences of Bosnian War with the help of DNA technologies (Pollack, 2001; Horigan, 2021; McNeil, 2022).

For instance, Foucault (2008) as an often-cited scholar in the biopolitics field, deals with power relations at the level of population politics and looks at genocides as a biopolitical technique to serve for political ends at the level of undesirable population. He shapes his ideas around the spaces and technologies that are developed through the relationship between power and knowledge. For him, systematically gathering data about life and manipulation of it with statistics is a rational act in the Western World to construct an ideal population and administer life for political and economic objectives, as outlined in *Reason d'Etat* for a state. Although his opinions are rather generalized and literature has applied his views in empirical data in numerous ways, Agamben (2013) contends what Foucault omits to explain the legal problem of stripping individuals of their humanity in excessive instances. Modern political power legitimizes the state of exception, often characterized by dehumanization of some. The argument is: to protect one life, the state can kill another.

Although I'll explain the theoretical framework of dehumanization very briefly here, we can still question the place and subjectivity of the subordinates in these mainstream frameworks. Very shortly, Agamben does not include the voices of the subordinate with an ethical frame, rather he limits his methods to his observations to the Nazi case, with a legal framework. On the other hand, Foucault's theory is useful for opening new horizons methodologically, in which a scholar could try to hear sounds of the oppressed as well. Yet, Foucault's genealogy is limited to the first wave of modernity and pays little attention to the place of sovereignty in times of exceptions and in times of crisis. But what is nice about these limitations of both approaches, is that they provide us a gap to make an inquiry about both the agencies and subjectivities of actors, where to place them and how ethically. Biopolitics, therefore, can serve as a canvas for thinking about the places of the medical doctors as agents, as well as resilient individuals in genocides in general, through a political lens. Such a critical stance allows for

capturing deeper layers of “othering” erode subjectivity, while foregrounding the ethical questions embedded in these processes.

Proceeding from the categorization that I mentioned above with *the medical doctors during the war* and *the medical doctors of the “others”* have helped in this inquiry. Testimonies and memories of the survivors, witnesses and the medical doctors through secondary sources, also informed us about the power relations regarding the relationship between medicine and politics profoundly. Consequently, I am observing the medical doctors’ actions, as both agents and the subordinates, during the Bosnian War, drawing upon the testimonies and memories of the survivors, witnesses and the doctors who experienced wars.

Thereby, walking alongside Gayatri Spivak’s famous question “Can the Subaltern Speak?”, survivors’ accounts and testimonies foreground the limits and conditions under which subordinated actors’ experiences become intelligible, rather than answering the question (Spivak, 1988a). This study understands forms of agency, remaining constrained by the power relations, rather than autonomous or emancipatory. Congruently, many doctors during the war, developed strategies to respect “human dignity” even under circumstances that silenced them, made them “invisible”, isolated at times, and “not counted as human beings”. Conversely, many others aligned themselves with structures of political power, becoming a part of the processes of dehumanization. This analytical division indicates that agency does not operate outside of the political power, but results in different modes of positioning within it (Spivak, 1988a; Spivak, 1988b).

Doctors During the War

There were doctors who had been pretty determined to remain ethical even under difficult circumstances such as lack of medical materials and anesthesia, food, bed etc. Some even had to practice outside in the woods, the mountains during Death Marches, or in the camps. They had to undergo surgeries while making equipment literally out of nothing, sterilizing a clipper using a cigarette lighter for a procedure (Lieblich and Boškalo, 2012, p.56), or using hydrogen peroxide to sterilize tissues (Fink, 2003, p.5). The ethical and personal backgrounds pushed the doctors into a position where they had to handle political and social circumstances around them too (Baiev and Daniloff, 2003). They felt as if they had to take part in the war as well, even though their oath was to sustain life. Fink (2003) explains this situation

as, doctors mixing medicine with advocacy, community organizing, and politics... “Some— with the painful conviction that they could save more lives by taking lives — shook off their white coats, picked up guns, and turned themselves into fighters” (Fink, 2003, p.xviii).

Due to their elite status and their hard work, medical doctors were embraced by the society in Former Yugoslavia. Not only because these doctors helped people to stay alive, but also made these patients feel like they were human beings that must be treated. There were also particular examples of non-Bosniak doctors who found ways to not only to keep patients alive with their interventions, but also did clandestine and dangerous things to get their Bosniak patients and friends out of the conflict zone safely (Friedman-Kasaba, 2024). Such doctors truly saw life as a human right as they chose not to act as agents of political power at the time.

Many doctors had to struggle between duties, safety and an uncertain future. Some doctors who were captured, or found refuge in safer zones tried to keep their diplomas with them, thinking they may need them to restart their lives in a different country and circumstances. Additionally, some felt like they had to prove that they were “good people” to the West as the primary arbiter “too big to be noticed” (Hochberg 2016, p.193). As Peter Maas tells, surgeons would bring their diplomas with them to prove that they were like Europeans with professional titles, but not religious fanatics (Maas, 1996, p.74). Or like, Aida, 34 years old, from Sarajevo who served as Yugoslav People’s Army (*Jugoslovenska Narodna Armija*) Doctor in the emergency room of the Military Hospital during the first days of the war, and tells how she had to manage politics at the hospital, and balance keeping herself and her family safe. Doctor Aida tells about her will to release soldiers from their duty, declaring them incapable of fighting because they would cry not to go to the front zones and eventually even she was listed for liquidation. After she witnessed the Serbian military takeover of the hospital, and the killing of patients under treatment, as a Muslim Bosniak she decided to leave for Belgrade with her kids. She recalls that she was the only Muslim in the plane (Julie et al., 1997, p.43).

Another aspect to consider is the safety in the war zones. As Fink (2002) noted, medicine can be considered an important tool in warfare (p.8). So, one should keep in mind that the life of doctors, even if they are not local, is very hard under shelling and fires. They were at times specifically targeted, wounded or killed even though they were under protection of the Geneva

Convention. Although their identities and roles were transparent, they were targeted regardless of their nationality (Helsinki Watch, 1992, s.78).

Furthermore, medical supplies were low throughout the region of the Balkans/Bosnia. Medical professionals lacked antibiotics, insulin and tools to administer anesthetics. David Brauchli, a photographer for the Associated Press, who was wounded and needed surgery, testified that he had to endure a surgery with only a local anesthetic which was not strong enough (Helsinki Watch, 1992, p.82). A WHO doctor, Jonathan C. Rendall, reports from Srebrenica, one of the most terrifying places to have been during the Bosnian war, “how in Srebrenica, he had to perform amputations with a garden saw, and that nurses performed major surgery because doctors could not handle the large number of incoming casualties” (Maas, 1996, p.282). Helsinki Watch too, reported that, despite the immense humanitarian needs, humanitarian aid couldn’t enter the besieged “safe zones”, because Serbian forces were obstructing delivery of any aid in accordance with their military agenda of starving people to death, or not letting ambulances in to prevent evacuation of those in desperate need of serious medical care (Helsinki Watch, 1992, p.82).

Some doctors thought that publicizing the conditions they experienced would help. But for some doctors, getting in contact with journalists presented two-sided ethical dilemmas. They wanted to reveal to the world what was going on, while on the other hand, remain respectful to their patients or “once-patients” and respect individual dignity. Peter Maas, a journalist, moans about the thirst of the Western journalism for war visuals popularizing the scenes of war, and their love for victims’ body (and bodily parts) counts as important in war depictions to global audiences. He was reporting from Slavonski Brod only a month after the war started. He went to a local hospital with a Canadian colleague to interview survivors and tried to get the count of bodies. The staff seemed too busy treating patients to count the dead, plus, the assignment looked almost impossible because most bodies were in multiple parts, so it was hard to see who they belonged to. Upon continued questioning by journalists, the doctor reluctantly agreed to show a small room with bodies collected (Maas, 1996, p.132-133).

Serbian and non-Serbian doctors treated patients under the ongoing fires. Although political pressures made it difficult to practice their duties, nevertheless some felt responsible for their colleagues or friends on the “other side”. They tried informing their friends which convoy was safe, and

which other was not. So, they passed along the information that was intended for their colleagues' relatives for safe evacuation. For example, an influential Serb doctor in Užice, Serbia, told his former colleague to tell his family which convoy his mother should take to be safe (Karčić, 2022, p.101). There were doctors like Esad Boškalo who remained calm enough to follow the Hypocritic oath when treating a well-known Serbian murderer, proclaiming "This is my infirmary. This is a wounded soldier, and he is going to stay alive", in front of civilians and an armed crowd who were in rage over that (Lieblich and Boškalo, 2012, p.25).

Political pressures included propaganda war involving doctors too. Non-Serb doctors were often the target of these propagandized messages. For example, Bosniak Dr. Mirsad Mujadzic was accused of preventing Serb women from giving birth to male children by giving women secret drugs; another Croat doctor, Dr. Zeljko Sikora, was named the "*Monster Doctor*" and accused of forcing Serb women to abort male babies, or castrate male babies upon birth (Karcic, 2022, p.114). Such war propaganda not only served for nationalist discrimination purposes, but they also diminished the credibility of doctors who did not fit the agenda well.

Doctors were accepted as an authority in the general Bosnian society no matter what their ethnic origin was. During the ongoing war, they also served as political agents, even mediators, and some had a chance to report what they witnessed in the courts. Mass rapes were reported mainly by doctors, along with some journalists. In regard to the situation of rape, they also described some of the procedures done on women who had to carry a pregnancy after the assault. Most women did not want to carry on pregnancies after they were raped. Previous Former Yugoslavia's laws permitted abortion only within the first three months of the pregnancy, which was deemed to be safe and ethical. Such medical practice was applied flexibly by the doctors for the raped women who wanted an abortion, if the practice wouldn't hurt them, justifying the situation based on the reluctance of raped women to give birth to a child in such improper social and political conditions, acknowledging the women's psychology as well (Stiglmeier, 1993, p.135).

Doctors of the "Other": Whose doctor?

On the other hand, there were doctors who were unwilling to provide medical assistance when they encountered a Bosniak patient. For instance, an older woman went to a Serbian doctor to get a prescription for her

chronic health problem, as she always did before. The doctor, however, looked reluctant to provide her with care or to prescribe the medicine. At first, she could not understand why, but then she remembered after the doctor told her that she would not need the prescription anymore, after the Serbian occupation of her town the other day (Džunuzović, 2017). We can see that at this point, her life was not seen as a relevant life to be enshrined by legal rights. Rather, at that point she was stripped from her human status as she was eventually going to be killed anyway, and therefore her life was not worth preserving.

A similar incident of invisibility is reported by Helsinki Watch (1992) when some women reported their rapes to the doctors: “The doctor took their names, and a gynecologist and psychiatrist were also notified that the women had been raped. However, the doctor did not file a complaint with the authorities. After that, women didn’t dare to complain anymore. The tank drivers came looking for the (*those*) seven who complained but, fortunately, the women had left the day before” (p.186). In another example, in Dece, Ferhat Avdić’s death caused by brutal beating, was reported falsely by the doctors as a death due to natural causes to cover up the murder of this Bosniak man (Karčić, 2022, p.186).

The consent and motive for treatment was another problem in detention camps. Doctors who treated detainees in those camps often did not provide the best medical assistance. Rather the motive was only to just make them healthy enough so that the camp commanders could use them to dig trenches, clear mines, or do other labor at the front lines. Indeed, the consent for treatment in such cases was recreated in a hegemonic way through biopolitical technologies, mainly through starvation (Tiro, 2024).

Medical realm during wartime became highly politicized. When doctors align themselves with dominant political agendas, the potential for a brutal outcome, akin to “authorized mass destruction” emerges as a grave consequence of such cooperation among doctors and politics. In fact, their support may become the foundation for immoral practical and political decisions and turn into a guiding principle for war crimes (Tiefenbrun, 1999, p.136). In accordance with this potential in Bosnian War, particular doctors had political roles to shape the course of the war from the beginning. For instance, Radovan Karadžić, a former psychiatrist, presided over Serbs

in Bosnia with Milosevic's support, and their "ethnic cleansing policy" (Lieblich and Boškalo, 2012, p.19). Some doctors agreed to become a part of the nationalist propaganda which was aggressive towards people who were patients of those doctors before the war. For instance, "Dr. Milivoje Kićanović was one of the main propagandists who spread the lies of Muslims attacking the hospitals in Bijeljina" (Džunuzović, 2017, s.293). Along with their role in propaganda, some doctors also took part in "war presidencies", directed ethnic cleansing in Foča, like Radovan Mandić and Sekula Stanić (Džunuzović, 2017).

Interestingly, some doctors didn't have to play a political role directly in Bosnian War. Diplomacy became an international tool where the occupational gowns and lenses were taken off by some doctors. Lord Owen, who had a political influence of the "West" supporting the unjust power dynamics during the Bosnian war, was an example. The unbalanced systematic power relations during the war were reinforced by certain Western narratives, such as civil war, ethnic conflict, and provocation on all sides. These narratives were not accurately describing the realities of the Bosnian War, creating a horrifying bubble of dehumanization and isolation for the Bosniaks to experience and feel lonely in the world. Lord Owen, who served as a physician before he stepped into politics, added to these obscuring narratives with his description of the war at the press conference on July 6, 1993, when he said, "I don't think this war has ever been quite as simple as aggressor or victim... There are elements of aggression, there are elements of civil war, there are elements of provocation on all sides" (Maas, 1996).

Conclusion

Doctors have always been an important element of power relations. For the Turkish case, they took political responsibility in modernization, for the French case, they became pioneers of creating a perfect population that would serve their nationalistic goals, while for the German's case, they worked as active agents in Nazi racial hygiene program. These roles demonstrate the elitist and undeniable political role of the medical doctors in a spectrum of ways. However, a line must be drawn by ethics regarding the problem of dehumanization that medical professionals sometimes take part in, when politics meet medicine.

Dr. Fink (2003) asked while observing the doctors' practices in Srebrenica under siege, "Were the ethics of medicine in wartime truly identical to the

ethics established for peacetime?” When considering how easily even the lives of medical doctors can be dehumanized during peace-time situations, it becomes more imperative to hear and contemplate the voices of the doctors when they demand full visibility and dignity for both themselves and their patients, during and after the war.

To contemplate on that need, words by Dr. Fatima Dautbašić-Klempić (2016), which highlight the power to reclaim the humanity for a doctor, as well as an individual: “*Whether or not I survive, I wanted to decide [things about] my own life.*” I hope we witness a day in this world where young people, children, women and any other person does not have to exert effort to reclaim their inalienable humanity.

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MEDICINE, ETHICS, AND WAR: LESSONS FROM BOSNIA AND HERZEGOVINA

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Abstract

The Bosnian War (1992–1995) stands as one of the most striking examples of how medicine, ethics, and humanitarian principles are tested in conditions of extreme violence. This paper provides a concise background to the conflict and examines how the core values of the Geneva Conventions—protection of civilians, neutrality of medical services, and respect for human dignity—were repeatedly violated. Hospitals were targeted, medical staff worked under siege, and access to care became a matter of survival rather than right. By reflecting on these failures, the article argues that the Bosnian experience offers vital lessons for contemporary medical professionals and students: it highlights the moral responsibilities of medicine in war, the fragility of humanitarian ideals, and the enduring importance of ethical courage when humanity itself is at risk.

Key words: war medicine, Bosnia and Herzegovina, humanitarian principles, Geneva conventions

Introduction

The war in Bosnia and Herzegovina (1992–1995) stands as one of the most devastating episodes of armed conflict in post–Cold War Europe. Emerging from the violent disintegration of the Socialist Federal Republic of Yugoslavia (SFRY), the war was rooted in a complex web of historical, political, and social factors. The conflict combined deep-rooted ethnic divisions, competing national projects, and the failure of both domestic and international actors to prevent escalation of violence. In addition to the catastrophic human toll, the war exposed the collapse of institutions essential

for civilian survival, most notably the health sector, creating conditions that would test the moral and ethical boundaries of medical practice in wartime.

This paper provides an overview of the conflict in Bosnia and Herzegovina and its humanitarian consequences, examining them through the lens of international humanitarian law and the Geneva Conventions. It argues that the war in Bosnia and Herzegovina remains a crucial case study for understanding the ethical dimensions of medical practice in wartime and offers enduring lessons for safeguarding humanitarian principles in future conflicts.

Context of the war in BiH and Humanitarian Consequences

The origins of the conflict can be traced to the late 1980s, when economic decline, rising nationalism, and weakening central authority eroded the federal cohesion of Yugoslavia. Following the death of Josip Broz Tito in 1980, the delicate balance that had held together the federation's six republics began to fall apart. Serbia's leadership, under Slobodan Milošević, exploited nationalist sentiment to consolidate power, pursuing a vision of a "Greater Serbia" that threatened the autonomy of other republics (Ramet, 2006). Meanwhile, Croatia and Slovenia sought independence, leading to armed conflicts in 1991 that foreshadowed Bosnia's descent into war.

Bosnia and Herzegovina occupied a particularly fragile position within this shifting geopolitical landscape. A multiethnic republic with a population composed of roughly 44% Bosniaks (Muslims), 31% Serbs, and 17% Croats (Statistički godisnjak Jugoslavije 1991), it was both ethnically mixed and politically divided. While the majority of Bosniaks and Croats voted for independence in the March 1992 referendum, Bosnian Serb leaders, backed by Belgrade, rejected the results and proclaimed the formation of the self-styled Republika Srpska in BiH. Soon after, Bosnian Serb forces, supported by the Yugoslav People's Army (JNA), launched a coordinated military campaign aimed at establishing ethnically homogenous territories through the systematic expulsion of non-Serb populations (Toal & Dahlman, 2011).

Over 100,000 people were killed and around two million were displaced, making nearly half of Bosnia's pre-war population refugees or internally displaced persons (WBG 2024). Civilians were the primary victims—subjected to campaigns of ethnic cleansing involving mass executions, forced deportations, and the destruction of cultural and religious heritage. The genocide in the UN protected safe zone in Srebrenica in July 1995, in which

more than 8,000 Bosniak men and boys were executed by Bosnian Serb forces under the command of Ratko Mladić, became the most horrifying symbol of the international community's failure to prevent war crimes. Genocide in Srebrenica was confirmed by both the International Criminal Tribunal for the former Yugoslavia (ICTY) and the International Court of Justice (ICJ).

Widespread sexual violence, particularly against Bosniak women, was systematically employed as a weapon of war to instill fear, humiliation, and ethnic terror. These crimes later led to landmark international legal recognition of rape as a crime against humanity and an instrument of genocide (Power 2002).

The siege of Sarajevo, lasting from April 1992 to February 1996, became the longest siege in modern European history, claiming over 10,000 lives and subjecting residents to continuous shelling, sniper fire, and deprivation of food, water, and medical care. (Malcolm, 1996). The city became an open-air prison and a symbol of both resilience and abandonment.

The international community's response was characterized by hesitation and internal divisions. The United Nations imposed an arms embargo that effectively disadvantaged the Bosnian government, while the UN Protection Force (UNPROFOR) often lacked the mandate or resources to protect civilians. International intervention only became decisive after the genocide in Srebrenica and the shelling of the Sarajevo marketplace (Markale) in August 1995, which finally triggered NATO air strikes against Bosnian Serb positions and led to the Dayton Peace Agreement in December 1995 (Belloni, 2007).

Medical ethics during the war in BiH: Between neutrality and responsibility

The war in BiH represented not only a political and humanitarian catastrophe but also a profound ethical crisis for medical professionals. The destruction of hospitals, the targeting of civilians, and the total collapse of the health system transformed medical practice into a struggle for survival.

Before the war, Bosnia and Herzegovina possessed a well-organized and relatively advanced healthcare system, but the onset of hostilities in 1992 led to its rapid disintegration as hospitals were shelled, supply routes severed, and staff displaced or killed (Hodžić, 2007).

In besieged cities such as Sarajevo, doctors performed amputations and emergency surgeries by candlelight, often without anesthesia or sterilized instruments. These conditions blurred the boundaries between professional ethics and survival tactics, forcing medical practitioners to redefine the meaning of “do no harm”. This is reflected in the testimony of a doctor from Sarajevo hospital during the war:

“Despite heated political rhetoric, nobody in the health care system really expected a war. No preparations were made, no stockpiling of medications, no reorganization plan to help us quickly adapt to wartime conditions – if the need arised. As a result, the hospitals in Sarajevo ran out of basic surgical material (dressings, bandages, sutures, cleaning solutions, and similar) within the first three months of the siege. Essential medications, oxygen, and anesthetic gases were at a premium, and the power and water supply were cut off after several months (Šimunović 2 :2007)

Resource scarcity was a defining ethical dimension of wartime medicine. Lacking anesthetics, antibiotics, and blood supplies, doctors were forced to improvise with rudimentary materials. Veterinarians assisted in surgeries, dental anesthetics were used for operations, and heating pipes were repurposed for sterilization. The ethics of triage—deciding who receives care first—became an unavoidable daily practice. Medical staff had to weigh patients’ survival chances against the availability of resources. In this context, communities organized blood donations, women volunteered as nurses, and citizens risked sniper fire to deliver food and medicine to hospitals (Pitić, 2020).

Testimonies of medical professionals reveal the unbearable tension of trying to uphold medical duty amid chaos, fear, and violence:

“In war, the rules of civil society do not apply. Our unquestionable right to live suddenly becomes very questionable when we realize that authority and power lie in the hands of those with guns. And there were many of “those with guns wandering around the hospital, enraged, drunk or drugged, barging in everywhere, even the operating rooms during surgeries. We were scared, to death, but we at least had to pretend to have the situation in the hopsital under control.”(Šimunović 2007: 4)

Hospitals, which should have been spaces of protection and healing under the Geneva Conventions, became unsafe and stripped of neutrality. The principle of medical neutrality was frequently violated during the conflict.

Medical staff were kidnapped, threatened, or pressured to prioritize patients based on ethnic affiliation, while ambulances and hospitals were deliberately targeted (Leaning 1999).

The destruction of infrastructure and the total siege of many towns forced doctors and civilians to improvise entire medical systems under extreme conditions. With hospitals bombed or cut off from electricity, water, and supplies, basements, schools, and abandoned buildings were transformed into improvised operating rooms. These improvised war hospitals became lifelines for thousands of wounded civilians and soldiers. In these conditions, doctors and nurses displayed extraordinary resilience and creativity—crafting blood transfusion systems, making homemade pain reliefs, using rakija for disinfection, and sterilizing tools over open flames (Pitić 2020).

One of the most symbolic humanitarian efforts of the war were *Putevi spasa*—the “Roads of Salvation.” Dug through forests and rough mountain terrain by civilians and soldiers, these improvised routes connected isolated, besieged areas with Bosniak-controlled territories. These improvised roads became the only passages for evacuating the wounded, transporting food, and delivering vital medical supplies. (Pitić 2020) The Roads of Salvation were more than logistical routes; they embodied the determination and resilience of people in extreme conditions. Together, these improvised hospitals and secret roads represent the spirit of medical and moral resistance that emerged in the most challenging times of war in BiH.

International humanitarian organizations such as Médecins Sans Frontières (MSF), the International Committee of the Red Cross (ICRC), and the World Health Organization (WHO) played crucial roles in providing aid, yet their operations also exposed the tension between neutrality and moral responsibility. Many Bosniaks perceived the international community’s cautious stance and refusal to confront perpetrators as a form of passive complicity in ongoing atrocities (Power, 2002). At the same time, many doctors who served in BiH faced the ethical frustration of “bearing witness without intervention”. Despite this, doctors were often the first to document evidence of torture, rape, and starvation and their records became crucial in international trials.

International responses and paradigm shifts

The war in Bosnia and Herzegovina reshaped the global understanding of humanitarian intervention and medical ethics in wartime. The Geneva

Conventions, adopted in the aftermath of World War II, form the cornerstone of international humanitarian law, defining the moral and legal obligations to protect the wounded, prisoners, and civilians in times of war. They enshrine the principle that even in conflict, humanity must prevail—that doctors, nurses, and medical facilities are to be safeguarded and allowed to operate without interference. However, during the war in BiH, these principles were repeatedly violated. Hospitals were shelled, medical convoys attacked, and health professionals targeted for aiding civilians across ethnic lines. The United Nations “safe areas” were established but could not be protected from attacks. The siege of Sarajevo and the genocide in Srebrenica clearly demonstrated how the norms established by the Geneva Conventions could be violated when confronted with aggression and state collapse.

In order to deliver humanitarian relief, the United Nations Protection Force (UNPROFOR) was established in 1992. This was the first UN peacekeeping mission deployed to a country in the midst of an active war, with the mandate to ensure the delivery of humanitarian aid and to protect designated “safe areas” such as Sarajevo, Srebrenica, Goražde, and Žepa (UN 1996). Nonetheless, the UNPROFOR operated under a highly restrictive mandate that prioritized impartiality and consent over enforcement. This limited framework left peacekeepers without the authority or resources to prevent atrocities or defend civilians against armed aggression. The tragic fall of Srebrenica in July 1995, despite the enclave’s UN “safe area” status, exposed the mission’s profound shortcomings and became a symbol of the failure of the international community to protect civilians.

The moral shock of ethnic cleansing, genocide and systematic rape in Bosnia and Herzegovina, followed by the Rwandan genocide, led to a profound shift in global thinking about sovereignty and intervention. The inability to prevent mass atrocities pushed the international community to question the principle of non-intervention and eventually articulate the “Responsibility to Protect” (R2P) doctrine in the early 2000s. At the same time, the establishment of the International Criminal Tribunal for the former Yugoslavia (ICTY) in 1993 marked a turning point for international justice, prosecuting figures such as Radovan Karadžić and Ratko Mladić and setting vital precedents for accountability in international law.

Apart from concepts of humanitarian intervention and R2P, the concept of human security emerged in the mid-1990s as a direct response to the failures of the international community in conflicts such as Bosnia and

Herzegovina. The conflicts of the 1990s exposed the limits of traditional, state-centered notions of security, which focused on territorial integrity and military stability while neglecting the protection of individuals from violence, displacement, and deprivation. The concept of human security was formally introduced in the 1994 United Nations Human Development Report, and it shifted attention from protecting borders to protecting people. In practice, this meant that issues such as access to healthcare, education, food security, personal safety, and human rights became central to understanding and addressing conflict. For post-war societies like Bosnia and Herzegovina, the human security approach encouraged a more comprehensive recovery strategy—one that viewed rebuilding hospitals, ensuring freedom of movement, and protecting minorities as essential to lasting peace

Together, these developments—humanitarian failures, institutional reforms, and evolving norms—made Bosnia a key reference point for later international interventions in Kosovo, Libya, and beyond.

Lessons from BiH for Medical Professionals

Studying the Bosnian War is deeply relevant for medical students, even those outside the Balkans, because it reveals critical lessons about the intersection of medicine, ethics, and humanity during times of conflict. The war blurred the line between medicine and human rights violations but also

produced severe physical and psychological trauma: amputations, untreated chronic diseases, malnutrition, and post-traumatic stress disorders (PTSD). Studying this allows future medical professionals to grasp the long-term health consequences of war, which are relevant to treating refugees, trauma survivors, and displaced persons in any part of the world.

The following statement of a doctor from BiH captures the unpreparedness and moral shock experienced by medical professionals suddenly pushed into the chaos of war:

“Becoming a wartime physician overnight was not an easy task. As medical students, undergraduate as well as graduates, we were only taught how to be life-long learners, clinicians, educators, researchers, and managers. We were not taught any skills that would be useful in war.” (Šimunović 2007: 2)

This statement highlights the contrast between the ideals of peacetime medical education—focused on healing and research—and the brutal

realities of practicing medicine amid destruction and fear.

Testomonies from Bosnia, indicate a broader lesson for global medical ethics—that education in medicine must also prepare medical professionals for crisis and humanitarian responsibility when the conventional framework of medicine no longer applies.

The war also attracted volunteer doctors and humanitarian organizations from around the world. It became a powerful example of global medical solidarity and the need for international cooperation in crisis zones. For students outside the region, this emphasizes that medical ethics and humanitarian responsibility transcend borders, religions, and national identities.

The international relations (IR) lens helps medical students and professionals see that war-related suffering does not occur in isolation—it is shaped by political decisions, international power dynamics, and failures of diplomacy. This perspective encourages doctors to recognize that health crises often have political roots and require advocacy beyond the hospital walls.

At the same time, it provides tools to understand humanitarian diplomacy—the negotiation and coordination between governments, NGOs, and international organizations (like the UN, WHO, or ICRC) to deliver medical aid and protect civilians. Medical professionals who understand these diplomatic processes are better prepared to work in or with global institutions and navigate complex political environments to ensure medical care.

Conclusions

The war in Bosnia and Herzegovina serves as a powerful reminder that medicine is not only a scientific discipline but also a deeply moral and humanitarian profession. The Bosnian experience makes us recognize that medical practice can never be separated from the broader political and ethical context in which it occurs. In times of war, doctors are not only caregivers but also witnesses and moral agents, often forced to make life-and-death decisions under immense pressure.

Understanding international principles—such as state sovereignty, humanitarian intervention, and the laws protecting medical personnel—remains vital for future medical professionals working in crisis zones. The

Bosnian conflict profoundly influenced global humanitarian thinking, leading to the reformulation of international norms and the emergence of the Responsibility to Protect (R2P) doctrine. It reinforced the importance of civilian protection, accountability, and the moral duty to intervene in the face of mass atrocities.

Today, Bosnia and Herzegovina remains a crucial case study for scholars and medical professionals alike. It continues to inform international responses to crises—from Syria and Yemen to Gaza and Ukraine—by reminding us that the protection of life and human dignity must lie at the heart of every humanitarian effort.

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“MY NAME IS FATIMA”

Fatima Dautbasic-Klempic, MD., TUZLA

My name is Fatima, and I am a survivor of the worst genocide after the Second World War and the Holocaust. I would like to remind you of some facts and share with you the pain that still lives in my heart. I will try to give you a better understanding of the situation in Srebrenica during the war, especially after its fall.

As you already know, thousands of people—particularly Muslims—were forced to flee during the aggression against Bosnia from 1992 to 1995. This event would later be called “ethnic cleansing.” Particularly in eastern Bosnia, Muslims were the victims of a brutal purge that involved murder, rape on a massive scale, and forced relocation. Images of the violence that happened there stunned the world.

I, myself, was part of it—working as a young doctor from the beginning to the end in Srebrenica’s war hospital with only a few of my colleagues and very poor equipment. The hospital was full of wounded people—young, old, women, men, and children—all suffering together, innocent and trapped in the hell of war.

From the beginning of the aggression in April 1992, doctors and nurses worked in the field, treating wounds with very poor equipment—domestic alcohol, homemade ointments, wooden leg immobilization, and clothing bandages sterilized in ovens. In July, we started working in the hospital, still under the same terrible conditions, without water, electricity, or medical supplies. Many people were wounded; many died from tuberculosis, simple infections, and hunger. Many small children died from diarrhea because we didn’t have any medications to treat it.

One of the hospital doctors, Dr. Nijaz Džanić, was killed in an aviation bombing. One young doctor, with a small group, managed to come through the mountains from Tuzla and brought with him medication. In the winter of 1993, another group of doctors tried to reach Srebrenica, but they were trapped and killed by Serbs.

Our work in those conditions is impossible to fully describe. We were surrounded in a small town without adequate medical supplies and without communication with the rest of the world for almost three and a half years. I was a young doctor with only one and a half years of experience—similar to my five other colleagues. None of us had any surgical training or skills. But what were we to do in those circumstances, when someone was dying and there was no possibility to evacuate them to a better hospital?

Many procedures we had only learned in medical school but never performed without a mentor or proper equipment. Now, it was time to do everything possible—with only our hands and our minds. We had to treat the wounded and train ourselves at the same time. The whole time, we tried to remain true to the fundamental ethical doctrine of medicine, but it was incredibly challenging.

During 1992 and 1993, we performed many operations without anesthesia. No matter how brutal it seemed, it was the only way to help. Amputations, treatment of deep wounds, and many obstetric procedures like manual removal of the placenta were done without anesthetics, antibiotics, or sterile gloves. According to medical doctrine, such pain is too strong to survive without anesthesia. I had the impression that I was doing something illegal. I even thought I should be punished one day for not following medical protocols. Sometimes I asked myself: Am I helping or harming people? At the same time, I knew I had no other choice. I was constantly frustrated, wondering how to do my job better and how to improve our working conditions.

At the same time however, I witnessed many miraculous recoveries—survivals of severe abdominal, thoracic, and even head wounds without surgery, treated conservatively and symptomatically. For me, that was confirmation that we were doing something right.

Before the war began, the town's population was approximately 9,000. After the horrible shelling and destruction of nearby villages, by early 1993, many families sought shelter in Srebrenica, and the population grew to 66,000. A humanitarian catastrophe was imminent. There was not enough food or drinking water, no shelter for everyone, no possibility to leave the town, and shelling continued constantly... Can you even imagine such horrible pressure on the people in that town?

The whole time, I kept asking myself—how cruel and brutal must our enemy be to keep so many people in such inhuman conditions?

In 1993, the situation became so out of control that the United Nations designated “safe areas” or “safe enclaves” in the region and sent troops to protect the Muslims. But the UN troops had a limited mandate and were insufficiently armed to keep the peace. In January 1994, the Canadian troops in Srebrenica were replaced by various units of Dutch soldiers. Srebrenica looked like a large prison, surrounded by strong Serb forces on the hills. Serbs were so close that they could see every step of every person in the town with the naked eye. Despite the UN’s guarantee of protection, Srebrenica was under constant shelling.

The humanitarian situation slightly improved after demilitarization, but food and medical supplies still depended on the Serbian forces. Most humanitarian convoys were turned back at checkpoints around Srebrenica because the Serb commanders refused to let them through.

The hospital remained full of wounded and ill people, despite the tremendous help of *Doctors Without Borders*, who tried to break through the Serbian ring and bring medical supplies, antibiotics, anesthetics, and staff. During 1994, we were able to work more effectively under somewhat improved conditions.

Only two evacuations of wounded people from our hospital were organized during the entire occupation. One occurred during preparations for demilitarization, and the second after the horrific bombing attack on April 12, 1994. A few thousand women and children left for Tuzla in UNICEF trucks that had brought food to town.

The situation worsened again in early 1995. Shelling became more intense, and food and medical supplies stopped altogether. Srebrenica was crying out for help, but no one recognized the looming catastrophe.

It culminated on July 11, 1995, when Serb forces finally penetrated the town. That day was the worst of my life. For several days I hadn’t gone home to eat, wash, or sleep—I stayed at the hospital with my colleagues, trying to save the wounded. But more and more wounded kept arriving, and the hospital was filled with screams for help.

On the morning of July 11, we realized Srebrenica’s fall was inevitable. We had to evacuate the hospital quickly and transfer the wounded and ill to the UN base.

At the same time, there was chaos in the town. Houses were destroyed from shelling, and there was screaming everywhere. I saw hundreds running in panic along the streets toward the UN base in Potočari, seeking shelter. Many children and elderly were among them. I recognized some of them as my cousins—for many, it would be the last time they saw each other.

I stood in front of the hospital, trying to say goodbye to my mother. We had to make the hardest decision—to separate. She would go to the UN base. My brother and I decided to try to reach Tuzla through the mountains. I thought the forest was my only chance to survive. Was it? I doubted it. Who could say, in that chaos, what the best decision was?

I suspected the UN forces would not be able to protect us. On the other side were the Serb forces, who would certainly not spare us. I feared rape—the worst kind of torture. Death would be better. But the UN forces *had* to protect us. That was their mandate. Knowing that the Serbs had violated the Geneva Convention on prisoners many times during the war, I became more convinced they were capable of murdering people in front of the whole world.

What should I do? I thought it might be the last time I would hold my mother. I felt desperate.

And then we had to leave. I decided I had a better chance in the forest—at least I could kill myself before being captured.

I expected the walk through the mountains to be hard, but I couldn't imagine the horror that followed.

We walked step by step in a long line because of the minefields around us. Between 12,000 to 15,000 people walked through the woods like a snake. At first, I felt courage, seeing that long column, hoping the UN would reach an agreement to let us leave in peace. But after the first day, it was clear—we were not protected. The world had left us alone, without water, food, or medicine, under heavy shelling and being chased by Serb forces.

We walked mostly at night and tried to stay hidden during the day. There was death everywhere, the screams of the wounded, and hallucinations. I can't forget the faces of the badly wounded who remained in the woods. As a doctor, I felt helpless... as a human being, I didn't even feel like a human. I felt like an animal surrounded by hunters. Again, I felt guilty—I'm a doctor, I must help people, save lives, but in that situation, I couldn't do anything—for anyone, not even for myself.

I tried to encourage people around me to stay strong and keep walking forward toward freedom. It wasn't an easy task—in those horrible conditions, taking care of others was incredibly difficult. From today's perspective, I still can't say what gave me the strength to do it.

I didn't know the right way to Tuzla. I was following the men in front of me desperately, as if they were my only connection to freedom. I was afraid to fall asleep and lose that connection. It could have been fatal. I didn't sleep. I didn't feel hungry. All I remember was searching for water. But there was no water. If we found any, it was from small rivers in the woods, often mixed with the blood of dead people lying everywhere. We suspected that the spring water was poisoned. But I didn't ask too many questions—I needed to drink. I didn't even think anymore. I followed my instincts. I walked and walked, trying to think only about tomorrow, hoping to survive and see my mother again.

After seven days and more than one hundred kilometers, I was lucky to reach a village near Tuzla. I felt I had been saved from hell. In that moment, I didn't know I was part of a small group of survivors. Many didn't make it. They were captured in the mountains or separated from their families in the UN base in Potočari—tortured, murdered, and thrown into mass graves. I couldn't believe that I had survived, even though I was just a weak woman.

I often visit the cemetery in Potočari. Standing in front of the white tombs, I ask myself: What kind of miracle is it that I am here, instead of lying beneath one of those tombstones?

A lot of time has passed, but the pain is still here. The memories remain strong in our hearts. Nothing has changed. Now I know that we will feel like this forever.

For the families—including myself—it feels like time stopped in 1995. We still can't believe that our relatives are lost forever. We're still waiting for their return. It is difficult to accept that someone planned to forcefully claim another's territory using monstrous methods—executions, slaughter, and deportation of residents. It's hard to understand how someone who claims to believe in God could murder another human being. How is it possible that someone who has their own children can murder someone else's child? In the name of what?

We are especially desperate because, even 30 years later, many of our loved ones are still not buried. Many remain in hidden mass graves, or in bags at the Commemorative Center in Tuzla, waiting for DNA analysis from their bones. That's all that is left—bones.

We still must fight against denial and minimization—to prove that what happened was genocide. Many of the war criminals who ordered and carried out the mass executions in Srebrenica have still not been prosecuted.

The Bosnian War was evil. It wasn't just a fight for territory. The Serb enemy was trying to harm the Muslim people deeply—not just to shoot them, but to torture them first. They didn't spare civilians, the elderly, or children. They didn't respect anyone or anything.

That creates a major moral and ethical difference between the two sides—between the aggressors and the victims.

I must say that, even today, we are witnessing similar violence around the world, despite the phrase “never again.” This causes even more trauma to the survivors of genocide and brings fear of a new war that could repeat the crimes of the past.

This means that, in the name of the innocent victims of genocide, we must raise our voices louder. We must fight for the truth.

In particular, medical professionals must stay strong and continue to fight for the sanctity of life, because the Hippocratic Oath is an obligation for all of us.

I hope that everyone will learn a lesson from our example—and make sure that something like this truly never happens again.

POST-WAR EXPERIENCES OF BOSNIAKS: A MEDICAL STUDENT’S PERSPECTIVE

Tuna Göktürk

Tuna Göktürk, TOBB ETÜ Medical Faculty, Student of 4th Class.

Growing up, I was always aware of this tragic part of history **namely Bosnian War and Srebrenitsa genocide**, especially since my mother is from Bosnia. However, the conference that was held at my university “TOBB ETU” has reignited my curiosity and deepened my understanding of this historical event...

This summer, during my internship at McGill University’s Montreal General Hospital, I had the opportunity to work in the Department of Psychiatry. I would like to share the experience of meeting one of my patients there -a man in his fifties, originally from Bosnia. He was one of the many young adults who lived through the Bosnian War, which lasted from 1992 to 1995. Realizing that he was around my age, and the age of my classmates, when the war began it was deeply moving and difficult to comprehend.

When he was admitted to our hospital, he was put under a “guard” order, meaning he was not in a state of mind to make medical decisions for himself, and court approval had been obtained by the medical team to keep him hospitalized in the interest of his safety.

He had a long history of inter-hospital transfers. When I first met him, he appeared agitated and aggressive; often refusing to follow hospital rules and at times expressing violent thoughts toward staff. He frequently said he wanted to harm himself, that he had nothing to lose, and that he no longer feared death.

As we slowly built trust, he shared that he had no surviving family members and no one whom he remained in contact with. Because of his suicidal thoughts, the doctors assigned a staff member to stay with him in his room 24 hours a day for his protection. Eventually, we transferred him into a lower-floor to reduce the risk of self-harm.

Although I couldn't communicate with him directly, as he spoke only Bosnian and French, I asked my colleagues about his condition so I could better understand it. They explained, and I quote: "There was a strong component of "post traumatic stress disorder" along with elements of a personality disorder that intensified his reactions. He experienced severe episodes of depersonalization and dissociation, accompanied by flashbacks, which would completely take over his thoughts and emotions."

In conclusion, this man represents just one of the approximately four million people who experienced the Bosnian War firsthand — and one of the countless individuals who lost their families and loved ones among the 100,000 Bosnians that were killed.

...

By chance during one of my paediatrics classes, my professor began speaking about what has been happening in Gaza. He then shifted the discussion to the Bosnian War, and showed us photographs from Bosnia—images taken during the war—. This sparked my curiosity again, and with his assistance, we found several books, or rather journals, written by Bosniaks, specifically children.

Children are known to have no filter, so what they wrote—and what eventually got published—captured their raw experiences and emotions during wartime. Reading these journals was another eye-opening moment for me. Even the titles alone carry so much weight. Take for example, "*Mama Neću u Podrum*" (2) which, when translated, means "**Mom, I Don't Want to Go to the Basement**". Or the diary kept by a 13-year-old girl, Nadja Halilbegović, whose honest words were written right in the midst of the war (3).

I would also like to add that the conflict between Bosniaks and Serbs had took place in the early 1900s. In November 1924, Boško Bošković was killed, and Yusuf Mehonjić was immediately blamed for the assassination, even though it was later proven that Mehonjić was in "*Arnavutovac*" at the time of the attack. In fact, the real reason Mehonjić was declared guilty had more to do with political motives: he publicly supported and protected the Muslim population, which made him an easy target for those seeking justification for retaliation.

This accusation directly triggered the Šahovići massacre. The massacre targeted the Muslim population of the village of Šahovići, today known as “*Tomasevo*”, as an act of revenge for Bošković’s murder. It was later revealed that Bošković was actually killed by members of the rival *Rovčani* clan, not by Mehonjić at all. In the massacre that followed, between 600 and 900 Muslims were murdered.

My great-great-grandfather was the cousin of Yusuf Mehonjić. One day, after stepping out to feed the animals, he returned to find blood at the entrance of his home. When he opened the door, he found all four of his siblings, along with his father, had been murdered. In 1926 two years after this tragedy, he migrated to Türkiye with his wife and kids to start a new life, changing his surname from Mehonjic to Ozyavas.

My great great grandmother Şerife and her spouse Zahir had decided, due to the ongoing Serbian oppression and the massacres being carried out against Bosnian Muslims, that they had to migrate for the future of their newborn child in 1914. Şerife and her family boarded a ship at **Bar Port** and traveled overseas for 40 days. After arriving in Karamürsel, Türkiye, the government relocated them to *Gömeç*. While learning about this from my grandmother, she stated that “Many Bosnians had passed away due to illness on the ship.” I remember hearing this from my grandmother made it feel real in a way history books never could.

A significant number of Bosnian Muslims migrated to the Ottoman Empire between the late 1800s and the early 1900s. Many left through the Port of Bar (then *Antivari*), Montenegro, especially after the Balkan Wars (1912–1913). From Bar, migrants typically traveled toward ports such as İzmir, İstanbul, and occasionally small Aegean ports.

Stories like these remind us that war is not just about politics or battles—it is about the people whose lives are torn apart, whose families are destroyed, and whose childhoods are stolen. From the patient I met in Montreal, to the children whose journals I have read, to my own family’s history, the human cost of conflict becomes vividly real. These are not distant events in some history book; they are lived experiences, filled with fear, loss, resilience, and, sometimes, survival against unimaginable odds.

Thanks to the conference that was held, I finally understand the words and stories my mother and grandmother shared with me as I was growing up. I can now say with pride that I truly know my roots. I am incredibly

fortunate that most of my family members are still alive, and I have had the privilege of hearing their memories, their struggles, and their resilience firsthand. These stories are precious, and I hope to preserve them, not just for myself, but to pass them on to future generations, so that the lessons of our past are never forgotten.

This has been an opportunity for me to connect with my family, to reflect on the strength and perseverance that runs through our bloodline, and to honor the lives of those who came before us.

- 1) Dr Razija Lagumdžija, *Mama Neću u Podrum*. Sarajevo, August 1992.
- 2) Nadja Halilbegović, *Sarajevo's Childhood Wounded by War*. MINISTIRY OF CULTURE, 1995.

ETHICAL DECISION MAKING IN CRISIS SITUATIONS FROM THE PERSPECTIVE OF DISASTER ETHICS: THE BOSNIAN WAR EXPERIENCE AND PHYSICIAN TESTIMONIES

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ABSTRACT

Wars and disasters represent extraordinary circumstances that challenge the well-established principles of medical ethics formed during peacetime. This study examines the ethical foundations of the disaster management cycle within the framework of the researcher's book, *Disaster Ethics*. Beyond the core principles of biomedical ethics, the study explores the conflicts and syntheses among utilitarianism, which prioritizes social welfare; deontology, grounded in duty and rules; and rights-based ethics, which advocates for individual inviolability in crises. This workshop compared the experiences of physicians who served during the Bosnian War with this theoretical framework. The Bosnian experience has been analyzed as a concrete example of tragic triage decisions under extreme resource scarcity, the struggle for medical neutrality against ethnic pressures, and moral injury. Consequently, it is emphasized that disaster management requires not only operational success but also the construction of an ethical memory grounded in solid theoretical foundations.

Keywords: Disaster Ethics, Bosnian War, Utilitarianism, Humanitarian Law.

INTRODUCTION

Wars, disasters, and large-scale humanitarian crises constitute contexts in which healthcare professionals encounter some of the most challenging ethical dilemmas. Under such conditions, physicians and healthcare personnel are required to incorporate not only their clinical knowledge and skills but also profound ethical reasoning into their decision-making processes. Uncertainty, resource scarcity, security risks, political pressures, and time-critical constraints continuously challenge the normative foundations of medical decision-making. The literature on medical ethics has primarily developed in the relatively stable, predictable conditions of peacetime. Situations of war, disaster, and crisis render the boundaries and vulnerabilities of these established ethical principles more visible.

In peacetime, a principlist approach clearly defines the core principles of biomedical ethics as nonmaleficence, beneficence, autonomy, and justice (1). In contrast, during war and disaster settings, factors such as security threats, limited resources, time pressure, insufficient information, unpredictable risks, and threats to the lives of both the injured and healthcare providers fundamentally alter the context of medical practice. Consequently, medical interventions are conducted not under standard conditions but in a crisis environment, often described as the tactical field. Disaster ethics does not advocate for the implementation of the theoretically optimal option, but rather for the application of the most humane and most beneficial option available under the circumstances. In such settings, failure to make rapid decisions and provide effective interventions in the prehospital phase is associated with high mortality rates. Because emergency medical care and decisions made in the field directly affect survival outcomes, context-specific practices tailored to crisis environments are required (2–4).

The Centre for Research on the Epidemiology of Disasters (CRED), in collaboration with the World Health Organization (WHO), defines disasters in the International Disaster Database (EM-DAT) as situations or events that exceed local capacity and require the request for external assistance at the national or international level. Disasters are sudden, unpredictable events that cause substantial damage, destruction, and human suffering. To be included in the EM-DAT database, which focuses on major disasters, at least one of the following criteria must be met: 10 or more deaths, 100 or more people affected, a declaration of a state of emergency, or a call for international assistance (5,6).

According to the World Health Organization (WHO), a disaster is an event that disrupts normal living conditions and causes suffering beyond the coping capacity of the affected community (7). Events leading to disasters are classified in the EM-DAT database (6) into two main categories: natural and technological. The most fundamental approach to disaster classification is based on whether the origin is natural or human-induced. According to the classifications of EM-DAT (6) and Kadioğlu (8), disaster-causing events include the following: natural hazards such as earthquakes, tsunamis, volcanic eruptions, floods, and droughts; and human-induced hazards such as wars, terrorist attacks, explosions, fires, accidents, and deforestation.

Regardless of whether they are natural or human-caused, disasters have serious societal consequences and can result in high levels of mortality and injury. For this reason, countries have developed integrated disaster management systems and national response plans encompassing the phases of risk reduction, preparedness, response, and recovery (9). The Hyogo Framework for Action and, subsequently, the Sendai Framework for Disaster Risk Reduction covering the period 2015–2030 were adopted with the aim of enhancing disaster resilience and have emphasized a holistic and institutional approach to disaster management (10,11). However, these frameworks have predominantly focused on structural, administrative, and operational dimensions, while the ethical foundations of decision-making processes have been addressed only to a limited extent. The book *Disaster Ethics* (2) seeks to contribute to fair and justifiable decision-making processes in crisis situations by integrating ethical principles into integrated disaster management systems.

In the book *Disaster Ethics* (2), the integrated disaster management cycle is examined within the framework of the Hyogo and Sendai Frameworks. Ethical considerations are positioned at the core of the disaster management process. As an original contribution, the book visually presents the presence of ethical principles across each phase of disaster management—risk reduction, preparedness, response, and recovery. Disaster ethics is not confined solely to ethical issues within the context of disaster medicine; rather, it encompasses multiple dimensions, including public health ethics, management ethics, media ethics, human rights perspectives, and volunteerism. Accordingly, disaster ethics is defined as a comprehensive ethical framework that guides all stages of disaster management, from the delivery of healthcare services and disaster logistics to triage decisions and the fair allocation of resources.

Disasters and Ethics

In crisis situations, such as disasters, decision-making must be rapid and often conducted under conditions of uncertainty. Decisions made during disasters, as well as the intervention strategies and policy choices implemented before and after such events, may be grounded in different ethical theoretical approaches. Within the disaster ethics literature, two of the most frequently applied evaluative frameworks are utilitarian ethics, which prioritizes the maximization of overall societal benefit, and rights-based ethics, which emphasizes respect for individuals' fundamental human rights. Utilitarian ethics seeks to achieve the greatest good for the greatest number by promoting the efficient use of limited resources in disaster settings. In contrast, a rights-based ethical approach prioritizes the protection of each individual's equal and inalienable rights, even under disaster conditions, independent of calculations of collective benefit (2).

According to the utilitarian approach, the moral value of an action is determined by its consequences and the benefit it produces. From a utilitarian perspective, an action is considered good or right only to the extent that it generates utility; no criterion beyond utility is required to assess the moral worth of actions (12). In contrast, within deontological ethics, actions are evaluated as morally right or wrong, good or bad, based on the nature of the intention underlying the action, independently of their outcomes. Consequently, this approach differs fundamentally from the utilitarian view that equates the highest moral good with the maximization of overall social benefit (13).

From the perspective of ethical theories concerned with justice, the *Dictionary of Bioethics Terms* defines justice as “*the principle stating that no arbitrary discrimination should occur against any individual in the distribution of fundamental rights and duties, as well as social benefits and burdens.*” This definition also corresponds to one of the core principles of biomedical ethics (14).

Kuçuradi argues that, in the history of philosophy, the question of what justice is does not lend itself to an easy answer; rather, justice is a difficult concept to define and is best understood by examining what constitutes injustice. Injustice, in turn, arises when fundamental human rights are violated or when there is a failure to intervene in such violations. For this reason, demands for the protection of rights may be regarded as a fundamental indicator of justice (15).

Aristotle conceptualizes justice under two main categories: distributive justice and corrective justice. Corrective justice aims to restore fairness by equalizing resources between parties rather than addressing structural inequalities. Distributive justice, while upholding the principle of equality in the allocation of benefits, prescribes differential treatment for cases of unequal need and merit by taking into account differences in need and merit. According to Aristotle, justice is achieved by giving each individual what is due to them in proportion to their entitlement, thereby establishing a balanced mean (16–17).

In *A Theory of Justice*, Rawls examines the concepts of liberty and rights from the perspective of equality of opportunity in order to achieve social justice. By extending the social contract theories of John Locke and Jean-Jacques Rousseau, and grounding his approach in Kant's conception of justice, Rawls aims to articulate a more advanced and comprehensive account of justice. According to Rawls, utilitarian theory fails to protect fundamental rights and liberties within democratic institutions. His conception of justice as fairness prioritizes fundamental rights and freedoms while integrating fair equality of opportunity with a democratic understanding of equality. For a just society to function, citizens must exercise their sense of justice by employing their capacities for moral reasoning and practical rationality. At the same time, economic and social balance must be ensured in the distribution of fundamental rights and duties across different segments of society (18).

Rawls's acceptance of inequalities insofar as they benefit disadvantaged groups may be regarded as one of the most fundamental considerations in disaster planning within the framework of disaster ethics.

Expected Ethical Conduct in Disaster Processes

In disaster management, prioritizing the common good over individual interests in the use of limited resources is essential not only in the provision of healthcare services but across all phases of the disaster management cycle. During both the provision and the request of assistance, taking into account the needs of other disaster-affected individuals constitutes an ethical obligation. In this context, it is imperative not to disregard the principle that all disaster victims possess equal rights (19).

Fundamental human rights are universal in nature and retain their validity under all circumstances. For this reason, ethical principles related to disasters

should be grounded in universal human rights. In disaster processes, it must be emphasized that respect for fundamental human rights is indispensable for disaster-affected individuals, humanitarian aid organizations, and all relevant actors, and that these rights cannot be waived even in extraordinary situations. Furthermore, to enhance awareness of these principles, it is important to systematically implement disaster awareness and education initiatives for the broader community (20).

Various ethical issues may arise during disaster processes. The personal rights and privacy of disaster-affected individuals may be violated, and the boundaries of privacy are frequently overstepped in media coverage. In epidemic situations, information concerning public health is not always shared with sufficient transparency. Such circumstances indicate that, in disaster response, particularly in the provision of healthcare services, the dignity and fundamental rights of disaster-affected individuals are not always adequately protected (21). It may therefore be argued that the protection and mitigation of existing or potential risks to society, the fair distribution of resources, respect for the dignity and personal rights of disaster-affected individuals, and the protection of their privacy constitute the foundation of disaster ethics (22).

In general, the ethical behaviors expected in disaster contexts include solidarity, shared responsibility, non-discrimination, humanity, impartiality, neutrality, cooperation, respect for territorial sovereignty, prevention, transparent information provided by the media, and careful attention to privacy (2,20).

The fundamental ethical principles that should be observed in the pre-disaster phase may be listed as equality and justice, transparency, respect for human dignity, cooperation and coordination, minimization of harm, accountability, prevention and risk reduction, respect for autonomy, cultural sensitivity, participation, prioritization of vulnerable groups, effective communication, environmental responsibility, sustainable development, empathy and compassion, the protection of humanitarian values, and the enhancement of awareness through education, training, and disaster resilience (23–27).

During disaster response, several fundamental ethical principles should be upheld. These include humane treatment under all circumstances and ensuring that decisions are made in the best interests of disaster-

affected individuals. The provision of humanitarian assistance, as well as guaranteed access to information and participation, is essential. Mandatory evacuations should be conducted within an ethical framework that respects human dignity and individual rights. Priority assistance should be given to vulnerable groups. In addition, rescue personnel must be protected and supported. Ethical disaster response also requires environmental protection and rehabilitation, along with measures to preserve and rebuild social bonds (19,20).

In the post-disaster phase, one of the primary ethical responsibilities is to assist all individuals equally and without discrimination. During this period, efforts should focus on strengthening societal resilience to the impacts of disasters. States are obliged to guarantee human rights during reconstruction and rehabilitation processes and to take necessary measures to protect economic, social, and cultural rights. Funeral and commemorative practices for those who lost their lives in disasters should be carried out promptly in accordance with religious and cultural traditions. Within the scope of civil and political rights, lost official documents and identification papers must be replaced quickly and through accessible procedures. Humanitarian aid must not be used in ways that result in discrimination based on religion, ethnicity, belief, nationality, or political opinion. Accountability should guide relief activities toward both disaster-affected populations and donors. Humanitarian organizations should refrain from acting as instruments of states' foreign policy. Disaster interventions should be conducted in cooperation with local capacities, and respect for cultural values must be upheld as a fundamental principle (2,20,28,29).

The International Committee of the Red Cross (ICRC) has identified seven fundamental ethical principles for individuals involved in disaster response. These principles summarize how people in need should be approached during armed conflicts, natural disasters, and other emergencies. The principles are humanity, neutrality, impartiality, independence, voluntary service, unity, and universality (30).

Discussion and Conclusion in the Context of the Bosnian War

Disasters are not merely physical events of destruction. They are also extraordinary situations in which the concepts of social justice, human rights, and medical ethics are tested to the limit. When the theoretical framework presented in the book *Disaster Ethics* (2) is combined with workshop data

from physicians who participated in the Bosnian War, it becomes evident that medical ethics moves beyond the relative comfort of peacetime and evolves into a tactical, and often tragic, context.

The Bosnian war has taken its place in the literature as one of the most severe ethical trials in the history of modern medicine. The experiences shared by physicians who participated in the workshop confirm that triage decisions were not merely clinical classifications but also moments of profound ethical fragmentation. This reality became evident in physicians' practices during the Siege of Sarajevo, where they were compelled to perform surgical procedures without anesthesia or to choose among salvageable patients due to severe shortages of medical supplies. These circumstances demonstrate how the principle of autonomy, central to peacetime medical ethics, is often overridden by a necessary utilitarian approach in times of crisis. However, they also reveal that even such utilitarian reasoning must be balanced by Rawls's concern for the protection of disadvantaged groups.

Ethical perspectives on disasters have historically developed mainly within the context of healthcare delivery in wartime settings. War and disaster conditions create extraordinary situations in which human rights may be severely violated. In this regard, ethical principles aimed at protecting civilians, the wounded, prisoners, and healthcare personnel have been institutionalized through international frameworks such as the Hague and Geneva Conventions. Therefore, the formulation of ethical principles to be applied in disasters should be grounded in International Humanitarian Law and international human rights principles (31,32).

Established to protect future generations from war, promote peace, and advance human rights, the United Nations plays a significant role in shaping the ethical framework of disasters. The Declaration affirms that everyone has the right to life, liberty, and security, and guarantees that no one shall be subjected to inhuman or degrading treatment (33). Moreover, regardless of changing circumstances, the concepts of justice and the right to health remain ethically fundamental to access to healthcare services. This is particularly evident in the allocation of scarce resources, where ethical considerations are central to ensuring equitable access to care (34).

Both international and non-international armed conflicts fall within the scope of international humanitarian law. Humanitarian law seeks to minimize the harm caused by armed conflicts by protecting civilians, medical

and religious personnel, and combatants who are no longer taking part in hostilities. Accordingly, methods of warfare and the use of weapons are subject to strict limitations. These restrictions are enshrined in international legal instruments, including the Hague Conventions of 1899 and 1907 and the Geneva Conventions of 1949. While the Hague Conventions primarily focus on limiting the means and methods of warfare, the Geneva Conventions prioritize the protection of persons affected by armed conflict (35,36)

The Geneva Conventions and related instruments, which constitute the core documents of international humanitarian law, prioritize the protection of children, women, and civilians who are not parties to armed conflict. These texts emphasize the need for special protection of groups that do not directly participate in hostilities. However, historical examples, particularly conflicts such as the Bosnian war, demonstrate that these protective principles are often violated in practice. This experience indicates that, in disaster and conflict settings, ethical and legal principles must be supported not only by normative frameworks but also by effective monitoring and enforcement mechanisms.

International humanitarian law and the Geneva Conventions define the neutrality of healthcare professionals as a fundamental obligation. Systematic human rights violations during the Bosnian War placed physicians in a dilemma between bearing witness and taking sides. In the accounts of physicians who participated in the workshop, the political pressures encountered while providing care in besieged hospitals, regardless of ethnic identity, destabilized the normative foundations of medical ethics resources.

The key conclusion that emerges is clear. Under conditions of war, ethical conduct serves not only as a clinical guide but also as a form of moral armor that preserves the physician's integrity of conscience.

The ethical injuries experienced by physicians who served during the Bosnian War demonstrate that disaster management is not merely an operational process but also a process of constructing ethical memory. As illustrated by the Bosnian case, the integrated disaster management cycle proposed in the book reveals that decisions made during moments of crisis shape not only the immediate outcome but also post-war social peace and the physician's own moral well-being.

War, disaster, and crisis settings remove medical ethics from the realm of abstract principles and place individuals face-to-face with the heavy

burden of decision-making. The experience of the Bosnian War showed that triage, resource allocation, and neutrality are not merely rules on paper but actions directly linked to human dignity. Preparedness for future disasters cannot be achieved solely by stockpiling medical equipment. It also requires strengthening this ethical memory and providing physicians with a normative ethical compass to guide them even in the darkest moments. The testimonies of Bosnian physicians once again demonstrate that disaster ethics literature is not merely a reflection on the past, but a necessity for enabling more just and humane decision-making in future crises.

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SIGNIFICANCE OF INFORMATION AND ETHICS OF DATA IN TIMES OF CRISES; A SHORT INTRODUCTION OF THE UNESCO-CODATA WORKING GROUP ON DATA POLICIES FOR TIMES OF CRISIS FACILITATED BY OPEN SCIENCE

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“I was home putting my baby to sleep. She was hardly 2 years old. Me, full of anxiety every mother knows very well as soon as they hold their babies for the first time. The anxiety that something bad may happen and the mother fails to protect her baby. An anxiety that keeps the mother awake even baby is sleeping in peace. We were living in a remote town, away from my parents. Our little baby, my husband, and I.

*I tried to ease my loneliness with books. I read a lot. One of the novels I came across was *Sevdalinka* by Ayşe Kulin. I will never forget the terror I felt when I walked through Nimeta’s pain and suffering at the scene where she had to pour the sour milk down the sink. I could smell the bitterness of war, helplessness of a woman and fading her hopes for her babies. My heart was pounding with terror when I read the rape and inhumane treatment targeted to all humans. With tears in my eyes, I looked at my own baby, puzzled, startled, and full of suffering. Then, as the details of war became more apparent, my astonishment grew into anger, disbelief and questioning. I was asking myself; “how come we were unannounced of such a tragedy in the middle of Europe? Why did not we have access to real time news when these were happening?”*

Same year as the Ayşe Kulin’s novel was published, Türkiye experienced a devastating earthquake. At 03.01-03:02 17 August 1999 an earthquake of 7.6 Mw hit Gölcük, Kocaeli province affecting Marmara Region and Istanbul for 37-45 seconds, leaving official estimates of 17,127 to 18,373 deaths, thousands injured, thousands missing, hundreds of thousands homeless. My husband, an orthopedic surgeon, joined the rescue team immediately. When he came back,

his tragic experience shed light on lack of information and absence of robust, real-time data that led to ineffective communication and chaos in response-rescue organizations. A very similar tragedy was there in the 2023 Hatay earthquake. We lost thousands of lives and shed many tears on heartbreaking experiences.”

After years of work in ethics, I got an invitation to get involved in UNESCO-CODATA Working Group on Data Policies for Times of Crisis Facilitated by Open Science, an international working group on data times of crisis. I was the co-chair of CODATA International Data Policy Center and the role for me in this working group was to highlight ethical issues related to data and right to science in crises times. When I got this invitation, I went several years back, visioned the frightened young mother holding her baby with fear, puzzled with lack of information about a huge tragedy, and thought that this would be a good opportunity to serve, a good opportunity to help to create concrete benefit for humanity.

Let me start by giving some background on the UNESCO Recommendation on Open Science. It was published in 2021 to establish the first global standard for open science, supported by a dynamic toolkit comprising guides, policy briefs, factsheets, and indexes. This toolkit has been continuously updated to reflect evolving practices and implementation progress, developed collaboratively with UNESCO partners and working groups. Our working group contributes to this resource by focusing on open science and data policy issues, specifically in times of crisis. The aim is to ensure that ethical principles of transparency, accessibility, and collaboration are upheld when data becomes critical for decision-making under urgent and high-stakes conditions.

The deliverables of the UNESCO-CODATA Working Group on Data Policies for Times of Crisis Facilitated by Open Science include guidance for policymakers and scientists, a practical checklist, and a factsheet—all tailored to crisis contexts. These tools aim to help stakeholders design and implement data policies that align with UNESCO’s Open Science Principles while addressing unique challenges such as immediacy, governance, and equitable access. The overarching objective is to provide adaptable, evidence-based resources that promote responsible data practices, foster collaboration, and support capacity building during crises. By embedding ethical considerations into open science frameworks, this initiative

strengthens trust and accountability, ensuring that data-driven responses serve the public good without compromising integrity or inclusivity.

UNESCO-CODATA Working Group on Data Policies for Times of Crisis Facilitated by Open Science task was to provide tools for various stakeholders to facilitate their work and hold the ethical compass on the table throughout the process. My role in this working group as an ethics expert was to identify ethical concerns in crisis data policies and propose strategies for integrating these principles into governance frameworks. Now, let me walk you through the ethics of data management in crises briefly;

In emergencies, the ethical stakes of data access, integrity, and responsible use, intensified by urgency, can tempt shortcuts that undermine privacy, confidentiality, and autonomy, eroding trust and complicating equitable resource allocation. The shared values of the UNESCO Recommendation on Open Science together with the right to information and the broader human rights agenda ground out a governance model that prioritizes transparent, inclusive, and evidence-based action.

Across prevention, preparedness, response, and recovery, the ethical concerns cluster around data sufficiency and flow, integrity and reliability, efficient resource allocation and interoperability, and data literacy for capacity building. The central ethical challenge is securing a seamless, trustworthy, interoperable flow of data while balancing rights-based safeguards with utilitarian imperatives to maximize benefits under severe time and resource constraints. In this balance, the right to science functions as a normative anchor: it affirms people's entitlement to access, benefit from, and contribute to scientific knowledge and data in crises, reinforcing proactive disclosure, equity in access, and capabilities for meaningful use.

A rights-based approach protects privacy, confidentiality, and informed consent as expressions of human dignity and autonomy. A utilitarian approach seeks to prevent irreparable harm by prioritizing rapid, efficient actions that benefit the many. In crisis contexts, scarcity—especially time—drives the tension between these approaches. The right to science bridges this tension: it justifies making reliable scientific data available for public benefit while constraining how such availability occurs, requiring good governance (transparency, inclusiveness, fairness), proportionality, and accountability. Temporary limitations on individual rights may be ethically defensible only when they are necessary, time-bound, and subject to oversight, and when

access to trustworthy data genuinely enables collective protection and recovery.

Operationalizing these commitments entails mapping Open Science values into practice: rights-based rules rooted in local legislation and treaties; human-centered design that includes less represented groups; interoperable infrastructures with trusted standards, protocols, and vocabularies; and trustworthy ecosystems that foster collaboration and long-term resilience.

Artificial intelligence, the disruptive technology that disseminates all domains of life, has an impact on ethics of data management in crises times. In AI scenarios—preparedness, response, and recovery—traditional and generative AI can support planning, simulations, decision-making, damage detection, and rehabilitation. Yet data integrity, bias, privacy, confidentiality, intellectual property, black-box opacity, and the digital divide pose significant ethical risks. Ethics-by-design across AI life cycles and transparency about where, how, and under what human oversight AI is used are imperative to sustain trust and justice.

We can conclude that future governance should integrate UNESCO's Open Science principles and human rights, uphold data integrity, respect for human dignity, and strengthen justice and public trust by integrating trustworthy and responsible use of artificial intelligence. Recognizing the right to science within crisis data policy clarifies both obligations and limits: authorities must proactively enable equitable access to reliable scientific data and knowledge, build capacity for data literacy, and ensure that any rights restrictions are proportional, transparent, inclusive, and oriented toward the collective benefit without abandoning the protection owed to individuals.

Section	Key Points
Framework	UNESCO Open Science values guide crisis data ethics: quality & integrity; collective benefit; equity & fairness; diversity & inclusiveness; flexibility.
Ethical Concerns by Crisis Stage	Prevention/Preparedness: data sufficiency, integrity, reliability; Response: resource allocation, interoperability; Recovery: data literacy & capacity building.
Core Ethical Challenges	Secure seamless, trustworthy, interoperable data flow; balance rights-based safeguards with utilitarian imperatives; operationalize Open Science values.
Right to Science	Normative anchor in crises: entitlement to access, benefit from, and contribute to scientific knowledge and data. Requires proactive disclosure, equitable access, and capability for meaningful use; constrains temporary rights limitations via transparency, inclusiveness, fairness, proportionality, and accountability.
Rights vs. Utilitarian Dilemma	Utilitarianism maximizes collective benefit under scarcity, but risks privacy, autonomy, and consent. Rights-based approach protects dignity and autonomy. The right to science bridges them: mandates availability of reliable data for public benefit while requiring rights-respecting governance (necessary, time-bound, overseen).
Open Science Mapping	Rights-based rules; human-centered inclusion of less represented groups; interoperable infrastructures (standards, protocols, vocabularies); trustworthy ecosystems for collaboration and resilience.

AI in Crisis Management	<p>Opportunities: planning, simulations, decision support, damage detection, rehabilitation.</p> <p>Risks: integrity & bias, privacy & confidentiality, IP, black-box opacity, digital divide.</p> <p>Ethics-by-design and transparent human oversight required.</p>
Future Directions	<p>Integrate UNESCO principles and human rights; uphold integrity, dignity, justice, trust; enable equitable access and data literacy; ensure proportional, transparent, inclusive rights limitations oriented to collective benefit without neglecting individuals.</p>

I would like to express my sincere thanks to all members of UNESCO-CODATA Working Group on Data Policies for Times of Crisis Facilitated by Open Science. I hope the outcomes of this working group pave the way to effective resilient data management systems for times of crises. So that no-one would be left in dark when they are most needed, which is crisis times.

Further reading and useful links:

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- UNESCO Recommendation on Open Science <https://www.unesco.org/en/open-science/about>
- The UNESCO open science toolkit resources: data policies for times of crisis facilitated by open science <https://codata.org/initiatives/data-policy/dptc/launch-of-the-unesco-open-science-toolkit-resources-data-policies-for-times-of-crisis-facilitated-by-open-science/>
- Launch of the UNESCO open science toolkit resources: data policies for times of crisis facilitated by open science https://council.science/wp-content/uploads/2025/06/DPTC-Launch-Programme_V3_Final.pdf
- UNESCO OPEN SCIENCE · TOOLKIT FACTSHEET https://council.science/wp-content/uploads/2025/05/676_25_Open-Science-factsheet_V2.pdf

Discussion and Q/A Notes:

Dr. P. Elif Ekmekci: (A Question to Dr. Fatima Dautbasic-Klempic) How did you restore your strength to practice again after the war as a medical professional? Do you have any suggestions for dealing with such difficult situations? Is it possible to think that what we discuss here can be considered a legacy from one generation to another?

Dr. Fatima Dautbasic-Klempic: One thought I had was that it was hard to improvise and it was very difficult to get prepared for difficult situations such as war and crisis. I believe it is important for the UNESCO disaster plan for the flow of information should be understood as the protocol. However, during the war, the United Nation forces asked me to scrap everything and then evacuate our hospital during the disaster. Our war hospital was located in Srebrenica while it was under siege. It was a small place, and it was hard to evacuate because it was not a safe zone and there was no place to move to. The United Nations didn't want to get involved and I should admit that it was disappointing on the day of July 11th when we had to evacuate the hospital and go to the United Nations base, but it was the only option. I still ask myself, how is it possible that I survived when my cousins and other men didn't make it? I can only suggest the medical doctors feel strong and do at that moment only what is possible. What helped me to restore my strength is my job, I am working in the labor and delivery department, helping to bring new life to this world. It is wonderful and enabling me to heal myself at the same time.

Esmā Nur Tiftikçi: Since the UN sometimes struggles to call certain events a 'genocide' and its investigations can seem one-sided, how was solid evidence gathered for the Bosnian War? Who should we trust when trying to understand what really happened? And what can be done to prevent similar tragedies and biased investigations in the future.

Adisa Avdic Küsmüş, Ph.D.: There is actually no confusion when it comes to the definition of the genocide, the definition is rather precise.

However, investigating atrocities during the Bosnian war was extremely challenging, especially because many areas were controlled by military forces and often described as "problematic zones" that even the United Nations

struggled to enter. Despite these limitations, genocide was proven — and this was possible through several key methods.

First, forensic science played a major role. After the war, mass graves were exhumed across Bosnia, particularly around Srebrenica. Through DNA analysis, it became clear that thousands of victims were killed in the same period and in the same manner, which showed a systematic pattern of execution. This scientific evidence was very difficult to deny.

Second, witness testimonies were crucial. Survivors, journalists, and even former soldiers gave statements describing forced deportations, rape camps, organized killings and military orders. Their testimonies were carefully checked and used in the trials at the International Criminal Tribunal for the former Yugoslavia — the ICTY in The Hague.

Third, documentation was found — military orders, political discussions, intercepted communication — all showing intent. And that is very important, because to legally prove genocide, you must prove intent to destroy a group. This specific intent, or “*dolus specialis*”, became the legal foundation for the genocide ruling.

International organizations such as UN experts, Human Rights Watch, Amnesty International, and the Red Cross also reported atrocities during the war. And later on, both the ICTY and the ICJ — the International Court of Justice — confirmed that genocide took place, especially in Srebrenica in 1995.

Now, regarding the question of “one-sided” evidence — the international courts work with a very high standard of proof. Every piece of evidence is checked, challenged by defense lawyers, and must be confirmed from multiple sources. So even if something appears one-sided at first, the legal process filters it. If it remains, it means it was solid and credible.

Finally, the most important part is: what lessons can we learn to prevent future atrocities?

The Bosnian case teaches us that we need:

- early warning systems to monitor hate speech and rising tensions,
- stronger UN mandates — not just peacekeepers who observe, but who can act,
- accountability and justice, because justice has a preventive effect,

- and also education, reconciliation, and memory — because denial is often the last stage of genocide.

In conclusion, Bosnia shows us that genocide can be proven, even in difficult conditions — but prevention is always better than waiting for justice after the fact. The responsibility lies both in international mechanisms and in local peacebuilding and education. That is how we can try to ensure that such atrocities do not happen again.

The confusion is in whether it is unacceptable proving a genocide is quite difficult we cannot report a genocide according to the media reports genocidal intent must be proved at the court, and the main proof should rely on the motive the intention on the genocide.

Dr. Nejat Akar: My question is to Dr. Fatima Dautbasic-Klempic. Did they invite you to the Hague / ICTY Court for a testimony or as a witness? Have you ever thought about going and testifying your experiences?

Dr. Fatima Dautbasic-Klempic: No, I wasn't invited to the Hague / ICTY to give a testimony, but the memorial center in Srebrenica recorded many testimonials in their archive, as well as mine. It is possible to use it any time.

Mirsad Krijestorac, Ph.D.: How much power do doctors have during the action? We know that doctors can act as both perpetrators and saviors. Is it possible to treat the “enemy” because it was ethical?

Doctors usually command clinics or spaces where medical aid is provided. How does that play a role in war, where command is not in the hands of the doctors or medical providers? Is that command over the medical space still in the hands of the doctors?

Dr. Fatima Dautbasic-Klempic: I was lucky that I didn't have to treat any enemy soldiers, but our soldiers in Srebrenica were not well equipped and it was not possible even to fight back. One day I remember a Serb soldier was captured and brought to our hospital and at night he was killed in the hospital bed. Our army detained the soldier who killed that Serb and brought him to court because it was against the legal framework to do what he did.

Başak Akar Özer, Ph.D.: I remember some testimonies including these grey zones, where we can learn about the power of the doctors under fire. There are doctors who had to treat enemy soldiers, despite the anger among the community and in the hospital. One of them testified that he protected a leading Serb nationalist from the community that surrounded the hospital

to take him, but he had to treat him as a regular patient, and he was under protection of the ethical protocols. However, there is no solid answer to your question as we encounter problematic grey zones about the medical practice as these professionals also deal with political authorities. Some may choose to obey the authority voluntarily and some may resist. Or some may do no harm but still follow the authorities' will and practices. I think the main question here we'll need to ask is whether we should include the discussion of the motives of the medical doctor under circumstances where s/he does not directly give harm to an individual but, his/her motive in treating the individual is not simply for that person's sake. Let me give you an example of Ramiz Tiro, who was held in two different Croatian nationalists' camps and survived in deadly circumstances. He was moved to another camp, where he would meet doctors there to treat his wounds and would make his health condition better. However, soon he realizes that if his health gets better, he can get a job at the camp and then get better access to food. He would also get fed better if he got drafted to work at the frontlines for the Croatians, and the doctors were the mediums for these drafts. Indeed, the doctors' treatment of the camp cannot be labeled as immoral easily, and, although limited, they do treat the captives. Based on this example, could political science and international relations learn from the grey zones of medical ethics by including the discussion of motive and limits of consent?

Dr. P. Elif Ekmekci: The main principles which should be followed by medical doctors have to be protecting human life and human dignity. Even under the darkest these must remain the core principles of our profession. Other principles and protocols should support and facilitate the realization of these main principles. Indeed, Dr. Özer has already mentioned in her presentation with a reference to Victor Frankl, prioritizing human dignity and being loyal to the Hippocratic oath might not be easy for the medical doctors as well. Remaining loyal to ethical principles and the core values of humanity is not an attitude we can refer to when circumstances are available. On the contrary, they are essential blocks for our profession that we need to address even when circumstances are not optimum such as deep fear, poverty, pain or war or crises times.

However, if we want to give an academic and technical answer to your question, we can discuss the normative ethical frameworks for crises and war times in two completely different theoretical bases: utilitarian perspectives and Kantian perspectives.

If one follows the utilitarian perspective, the consequences of an act would be the only subject for scrutinization. On the other hand, if one follows the Kantian approach, the motives should be accepted as a part of the action. If motives include the human dignity principle and non-discriminative purposes, the action can be translated as moral. Unless these frames are not taken into consideration, we are likely to observe violations of human rights, according to a Kantian perspective.

Aslı Göktürk: After the tragedy, my grandmother's father became very irritable, grumpy, and extremely meticulous. My family believes that his extreme focus on cleaning started after the genocide that happened to his family in their own house, where he found blood everywhere and he was the one who had to clean it. After that, he always walked around with a cleaning rag on him, washed his hands much more often than before, and it reached a level that could be considered OCD. Even so, he was never someone who liked to fight. In people who have gone through this kind of trauma, what have you usually observed? Our grandfather Cafer was never able to overcome it. Were you able to get results from your treatments? We read that a case was opened in Italy after it was discovered that a human safari was organized where rich people paid money to hunt Bosniaks. Have you ever heard or witnessed anything about this?

Dr. Fatima Dautbasic-Klempic: I can give an answer from my personal experience as an individual and a medical doctor. We are still trying to convince ourselves that not all Serbians were like that. We have to continue after this genocide, but time has stopped in Potocari, on July 11, 1995. Since then, it is hard to accept that almost nothing has concluded. Many of our beloved ones are still missing. I talked to my family about these changes and saw that it is not functional to nourish hatred. Anger is not only dangerous, but it also affects our own mental and physical health. We shouldn't hate. However, I sometimes see people asking for forgiveness. It is impossible. We cannot forgive on behalf of the buried. It is impossible to forgive. Indeed, our children help us a lot in moving on. You have to continue living, because you must think about your family members.

Regarding human safaris, yes, I believe it is true. People in Bosnia knew about it after the war. It was unhuman, unbelievable, and horrible. I hope that those who went to hunt and kill other people's children like animals will be prosecuted for what they did.

Concluding Remarks:

Başak Akar Özer, Ph.D.: As we are approaching our given stop time, I would like to summarize the themes that we as an epistemic community discussed. Dear Fatima Dautbasic-Klempic was here to share her experiences during Bosnian War as a medical doctor. She share her perspectives on the practices as a healthcare professional. But she also made a statement about dehumanization in general. She also told us her story of being left isolated and “unseen” as a human being during the war. Dehumanization takes place in many forms. Othering practices, which is a crucial part of a genocidal act, may include creating subhuman categories too. Dehumanization does not solely operate for social psychological reasons to reinforce national or ethnic identities, but it also becomes an object of an international consumption of the evil. The Sarajevo Safaris, reported by the journalist Peter Maass in 1991, has now become a part of the justice agenda after remaining unsolved for more than 30 years. My reference here to the “unresolved” thirty years does not concern the Sarajevo Safaris alone, but the unfulfilled pursuit of justice in the aftermath of the War: from unidentified bodies, the unburied or uncovered remains, the missing children and many other wounds that have remained open for the past three decades.

Today, we were here to elaborate the medical ethics during wartime and crises with an interdisciplinary perspective. We discussed the international status of the medical doctors in times of war and crises, knowing that these legal frameworks may not be to observe and easily conclude with unwanted consequences. We also underlined the importance of being extra sensitive towards the communities who had a collective and individual trauma. We learned that following the steps of trauma informed research may have a big help for the medical doctors and researchers who are counseling these vulnerable groups. We continued giving place to Bosniaks’ experiences of the War from the lens of a future medical doctor, where these experiences unearthed an unprecedented legacy in younger generations. The presentations informed the following notes, shared about the philice-suicide intentions in the war, and military-medical practices during times of disaster and crises. We also learned how important the ethical data sharing during crises and how these channels might be easily interrupted and corrupted by misinformation. Finally we discussed speculative cases along with the first-hand experiences of war by Dr. Fatima Dautbasic-Klempic and deduce that the ethical principle of “protecting the life and the dignity of the human

beings” must be followed even under darkest and disorienting circumstances.

I would like to thank TOBB ETÜ University and Faculty of Medicine, Ankara Yıldırım Beyazıt University and Bosniak Studies Initiatives for making this workshop possible. I would also like to thank Prof. Dr. P. Elif Ekmekci for her tremendous effort for opening an academic space for these discussions to find itself a concrete. There are numerous invisible contributors who invested their efforts and time in this event. TOBB ETÜ Faculty of Medicine International Bioethics Student Association, who ran the background of the preparations and IT services; Özlem Çanakçı for preparing the flyers and posters of this workshop adding her emotions, Belkis Karçaçaaçayır, Çiçek Çuhadar, Nuray Esim for running so many details smoothly without being noticed. I hope this workshop provides a basis for upcoming academic events and cooperations about medical ethics as well as Bosnian War.

Dr. P. Elif Ekmekci: Times of crisis, war, or disaster; the practice of medicine arguably represents one of the most challenging domains of our profession. In such circumstances, colleagues confronted with the demands of service delivery often express a sentiment I hear frequently: *“But we were not prepared for this; no one ever taught us what to do in these situations.”*

Undoubtedly, the lack of preparedness to which my colleagues refer does not concern their ability to perform medical interventions for the cases they face. On the contrary, what places them under strain, induces stress, and at times even paralyzes them, is the ethical and moral dilemmas inherent in such contexts.

This conference was an attempt to confront our students with one of the brutal wars of our recent history and to explore how medical doctors overcame the challenges they faced.

I sincerely hope that this meeting has succeeded in demonstrating that ethical and human values serve as moral compasses for physicians in times of crisis, and that they can provide guidance in navigating such difficult circumstances. I extend many thanks to all who contributed to this event, particularly to Dr. Başak Akar Özer, the TOBB ETÜ International Bioethics Society, and of course our distinguished speakers.

Yıllar Sonra Bosna Savaşı'nın İzleri

Fotoğraf Sergisi



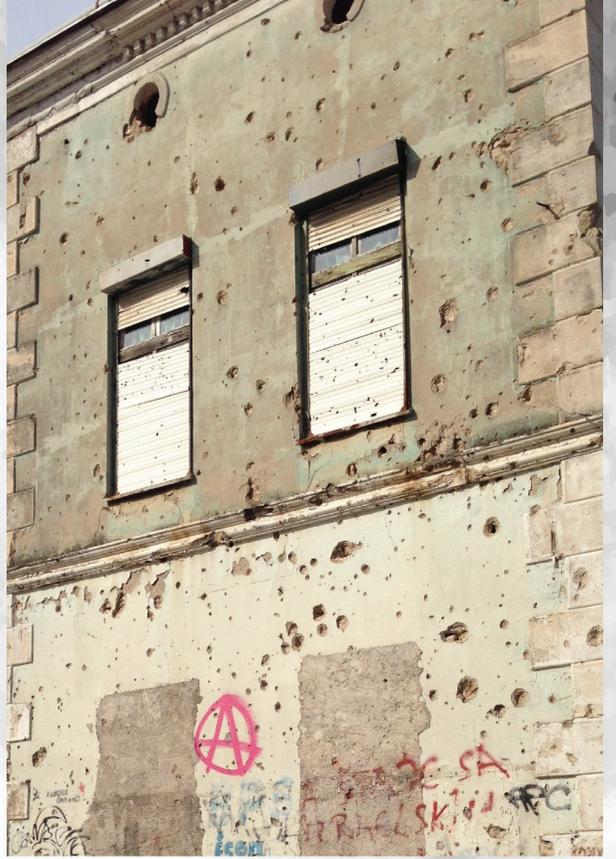
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"Asla Unutma, Asla Affetme : Srebrenica, 11.7.1995"

Kitap Kapak & Sergi Tasarımı 'Özlem ÇANAKÇI' tarafından yapılmıştır.

