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Decalogue of bioethics and primary health care: timeless, human, practical, and in danger of automation

Decálogo de bioética y atención primaria de salud: intemporal, humano, práctico y en riesgo de la automatización

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Abstract

To mention the word bioethics refers to human rights. The speed at which life is lived in the 21st century, in addition to constant adaptation,

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requires health professionals to standardize actions in instruments that guide and delimit decision-making in daily practice. To ensure that healthcare is fair and of high quality, the National Bioethics Commission (CONBIÓETICA) provides a document focused on humanization and the protection of the dignity and vulnerability of the Mexican population.

Keywords: person, bioethics, primary health care.

1.Introduction

In our country, Mexico, the Supreme Court of Justice of the Nation has issued jurisprudence emphasizing the Mexican State's constitutional obligation, in accordance with Article 4, regarding the right to health as fundamental to individuals, understood not only as physical well-being but also as the integration of psychological and social well-being (1).

Bioethics, as an imperative of the health sciences, is defined as: "the creative use of inter- and transdisciplinary dialogue between life sciences and human values to formulate, articulate, and, as far as possible, resolve some of the problems raised by research and intervention on life, the environment, and planet Earth" (PAHO Regional Bioethics Unit).

The Belmont Report is fundamental to bioethics, expressing four fundamental principles, which are grouped in Table 1.

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Table 1. Fundamental principles in the Belmont Report

FUNDAMENTAL PRINCIPLES			
Non-maleficence	***Autonomy***	***Beneficence***	***Justice***
(Primum non nocere): do no physical, psychological, or moral harm to patients. This implies assisting and not abandoning the patient, always respecting their dignity, equality, and autonomy.	Respect the freedom and responsibility of each person in managing their own life and health.	Requires doing and promoting good based on their autonomy, ensuring that they carry out their own life plan.	Treating equals equally and unequally. Guaranteeing equity in care.

Source: own elaboration.

Subsequently, another bioethical movement emerged in 1987, known as personalism, founded by Elio Sgreccia. Its postulates were:

- Promoting the integral good of the human person.
- Defense of physical life: a fundamental value of the person, who needs the body to exist.
- Totality of the human person: a therapeutic principle that indicates that it is lawful to intervene in one part of the body to heal the whole.
- Freedom and responsibility: individuals are free to pursue their own good, the good of others, and the good of the world.
- Sociability: individuals are part of a society and should benefit from the entire social organization, just as society benefits from individuals, from each person and from all people.

Why are some human differences singled out and considered noteworthy by social groups, while others are ignored? This fundamental

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sociological question frames the first component of the definition of stigma. For stigma to exist, there must be a social selection of human differences (2), but these labeled differences tend to be linked to stereotypes. It seems that we all make this link when we make quick judgments based on induction (3).

This chapter presents each point of the decalogue of bioethics and primary health care, based on the Mexican National Bioethics Commission, whose mission is to promote the knowledge and application of bioethics in the scientific, technological, and health fields, with a social and global perspective.

2. Recognizing each person, family, and community as the center of the care process

Primary Health Care (PHC) is defined as the approach to the organization and operation of the system, which seeks to provide thoughtful, comprehensive, high-quality, timely, available, and accessible care in accordance with people's real health needs. With the utmost and genuine interest of health personnel, who work as a team in an organized, coordinated, consistent, and effective manner, with the aim of keeping the population under their responsibility healthy. With ideal components of care that break paradigms, they are innovative and feasible and are oriented toward raising the level of health and quality of life of people (4). The fact that the concept of PHC includes the word "primary" leads us to think that it refers exclusively to the first level of care or the first contact. The PHC approach encompasses the entire system at all three levels of care and involves comprehensive community action, with a focus on the individual, the family, and the community.

To contribute to the overall social and economic development of communities, PHC has been adopted in various countries as a health system strategy, representing the first level of contact between individuals, families, and communities and the National Health System (NHS), bringing health care as close as possible to where people

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live and work. It is also the first element in an ongoing health care process.

Part of the conceptual framework of Primary Health Care on which this course focuses was taken from the Primary Health Care Performance Initiative (PHCPI), in which the WHO, the Harvard School of Public Health, the World Bank, the Bill and Melinda Gates Foundation, UNICEF, Results for Development, Brigham and Women's Hospital, among others, participated, available at *improvingphc.org*.

Implementing PHC would address more than 80% of people's common health needs throughout their lives:

- It increases people's well-being.
- Reduces maternal and infant mortality.
- Contributes to quality of life.
- Increases healthy life expectancy.
- It is efficient: it identifies, prevents, and improves people's health before diseases become costly and difficult to treat.
- It is fair and equitable, providing all people with access to essential health services in their communities.
- It helps communities detect and stop local outbreaks before they become global epidemics.

3. Respecting values, beliefs, and individual autonomy in health decision-making

To ensure the proper exercise of bioethical principles, especially the principle of autonomy, we will address the key role of informed consent in clinical practice. Autonomy is the principle that refers to respect for and the ability of individuals to make informed and conscious decisions about their own lives, especially in the context of medical practice (5).

In its early days, medical practice was mainly paternalistic, and what we now know as the deliberative method did not exist. Subse-

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quently, autonomy, as a social achievement, was obtained in stages which have always been hard-won. After Kant and the Renaissance, the concept of being began to change. To make an informed decision, individuals must have timely, understandable, and transparent information; otherwise, their decision will not reflect their will and will be subject to coercion (6).

An autonomous person is recognized as someone who has the right to choose, state their position, and make decisions based on their beliefs, culture, and principles (7). Thus, adequate information must be provided to patients so that they can make informed decisions and have their will respected, if they are capable and have given their consent voluntarily (5).

Informed consent, both in clinical practice and in human research, is considered a process, not a document. This guarantees not only acceptance by means of a signature, but also the interdisciplinary support throughout the time during which the patient or research subject remains actively involved.

For CONBIOÉTICA, informed consent is defined as: "the tangible expression of respect for the autonomy of individuals in the field of medical care and health research. It is not a document, but a continuous and gradual process that takes place between healthcare personnel and the patient and is consolidated in a document" (8).

For consent to be valid, it must precede any intervention and be carried out considering the social and cultural context of the participants (subjects and/or patients). This implies considering the characteristics of each situation in order to implement the process appropriately.

There are some mandatory components in the consent process for a person to receive a therapeutic procedure during their medical care or to participate in clinical research, namely: information, voluntariness, and decision-making capacity.

Assent is a variant of consent whereby a person who does not have the legal capacity to do so affirmatively expresses their agreement to participate in research or receive a therapeutic intervention (9). For example, in the case of schoolchildren, who have the capacity to understand the information provided in simple and clear language, since they cannot legally make decisions about themselves, even if their guardians give consent, they should give their assent before being included in a research study.

In other words, the participant's assent does not eliminate the need for parents or the legally authorized decision-maker to formally give informed consent. On the other hand, in the case of young children or people with dementia or cognitive impairment, assent is not considered necessary, and it is the legally responsible persons who participate in the informed consent process and record the process of obtaining consent in the relevant documents.

Often, patients are faced with the need to decide between different options with very similar potential benefits and risks. On the other hand, there is a dilemma between choosing one treatment over another given the possibility of very different short-, medium-, and long-term outcomes for the various therapeutic options. Thus, decision-making capacity means understanding the implications of choosing one treatment option over others.

As an example of progress in our country, Mexico, the SCJN has confirmed the right of persons with intellectual disabilities to make informed decisions about health care, derived from the obligations established in the General Law for the Inclusion of Persons with Disabilities and the General Law for the Care and Protection of Persons with Autism Spectrum Disorder, since this is not a condition that limits them from enjoying the highest level of access to comprehensive health care, whether in primary care or in highly specialized hospital settings (10).

4. Protecting the dignity and safety of people, particularly those in vulnerable situations

The National Human Rights Commission (CNDH) in Mexico works to protect, defend, promote, observe, study, and disseminate the rights of what we call vulnerable groups, defined as sectors of

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the population that, due to certain conditions or characteristics, are more susceptible to human rights violations and to finding themselves in situations of risk.

The issues related to these vulnerable groups, and on which the CNDH focuses its work, are: migrants, victims of crime, missing persons, children and families, sexuality, health and HIV, equality between women and men, the right to life, journalists and civil defenders, combating human trafficking, indigenous peoples and communities, persons with disabilities, and persons in detention.

Since 1948, the Universal Declaration of Human Rights has recognized dignity as an intrinsic right of human beings, equal and inalienable for all. It is a right inherent to all human beings, equal and inalienable for all. It is a right inherent to all human beings, such that dignity is not something that is acquired, but possessed by the mere fact of existence.

As the then president of the Inter-American Court of Human Rights, Antônio Cançado Trinidade, historically said about Article 3 of the Universal Declaration of Human Rights: "Arbitrary deprivation of life is not limited to the unlawful act of homicide; it extends to the deprivation of the right to live with dignity" (11).

These regulatory frameworks urge the recognition of each of us as dignified beings with equal rights in a health system created for our benefit.

5. Promoting self-care among individuals and shared responsibility within the community, in an atmosphere of solidarity

In the Astana Declaration, Kazakhstan, in October 2018, WHO member countries committed to implementing PHC as the foundation and future for achieving health for all people.

The focus of this implementation is on the individual, oriented towards maintaining and improving the health of individuals, families, and communities, with a positive vision of well-being. It acts

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proactively, focusing on prevention, comprehensive care, and health promotion, with a salutogenic approach. In addition, it empowers people to use their own resources and those of their environment to achieve the highest degree of well-being with or without illness.

PHC seeks to make all members of the community responsible for their health throughout the life cycle, considering the social determinants of health. Above all, however, people are viewed holistically and not just as individual diseases, which is why they are a fundamental part of Population Health Management.

PHC, as the foundation of health systems, would ensure that all people stay healthy and receive care when they need it. A robust PHC system has facilities located in strategic locations in their communities, where people can access the primary care services they need. It also has trained, empowered, and incentivized health care providers to deliver quality primary care with systems and policies that ensure the availability of essential, high-quality medicines, vaccines, and diagnostics.

Community participation is a process in which participants work together to address health issues and promote well-being to achieve positive health outcomes and results.

It is suggested that proactive population screening may be an effective strategy to ensure that people with chronic diseases receive follow-up care and adhere to the necessary medication.

Fragmenting or segmenting groups for proactive population screening according to risk profile (morbidity or mortality) can improve coordination and continuity of care, with the aim of targeting essential activities and ensuring comprehensive care for individuals.

6. Promoting effective communication based on trust between patients, family members, and healthcare teams

Communication with patients and among healthcare professionals themselves does not only take place through words; understanding

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local values, cultural practices, or taboos that influence the way people communicate is key to establishing effective and efficient communication.

To ensure respect and trust in a healthcare setting, these must be reciprocal between individuals and healthcare personnel, as they are a fundamental part of the quality of the care experience. This is often influenced by the individual's perceptions of the attitudes, competence, and affective behaviors of the service provider.

Respect means treating everyone who uses health services as equals, with the same value and dignity. It also means avoiding all forms of discrimination, violence, or abuse, including infantilization and scolding. It is expressed by showing interest in people, their beliefs, values, and preferences.

Social responsibility and community participation can help facilitate strong respect and trust between individuals and health personnel. Involving communities in health care early on can help align expectations between individuals and health personnel, as well as identify community needs. Engaging with communities to identify which services are most relevant and adapting to community needs is one strategy for building trusting relationships between communities and the health system.

7. Ensuring effective confidentiality based on trust between patients, family members, and the health care team

The rights and obligations related to the processing of personal data contained in a medical record, in the case of public health institutions, are contained in the General Law, 60 the LGS,61 and Official Mexican Standards, such as NOM 004-SSA3-2012,62 mainly.

Personal data is all information concerning or relating to an identified or identifiable natural person, such as:

- **Identification data:** name, address, RFC, CURP, etc.
- **Financial data:** bank accounts, balances, loans, properties, etc.

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- **Health data:** physical and mental health status, medical records, laboratory results, etc.
- **Biometric data:** fingerprints, iris, palm, etc.
- **Others:** ideology, political affiliation, religion, ethnic origin, sexual preference, etc.

In Mexico, Official Mexican Standard NOM 004-SSA3-2012 establishes that medical records are the property of the institution or medical service provider that generates them, when the latter does not depend on an institution. In the case of public sector institutions, in addition to the provisions of this standard, they must comply with the provisions in force in this area.

Notwithstanding the foregoing, the patient, as the provider of the information and beneficiary of medical care, has ownership rights over the information for the protection of their health, as well as for the protection of the confidentiality of their data, under the terms of this Regulation and other applicable legal provisions.

The protection of personal data is a human right that has its antecedent in the Universal Declaration of Human Rights, specifically the right to privacy (Article 12), which establishes the non-interference of the State in the private lives of individuals. The purpose of this right is to protect individuals in relation to the processing of their personal information. This right translates into the power of disposal and control that empowers the owner of the information to decide what data to provide, as well as to know who possesses that data and for what purpose, and to be able to oppose such possession or use.

It gives individuals the power to participate in the processing of their personal data by others, protecting the fair handling of such data through:

- Access
- Rectification
- Cancellation
- Objection
- Security Measures

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The right to personal data protection was first recognized in Mexico in the Federal Law on Access to Public Government Information of 2002. However, its development has allowed it to become an independent right, separate from the right of access to information.

Various countries around the world have enacted personal data protection laws, and each has sought to design and adopt legislation that addresses its own cultural, social, economic, and political conditions, as well as its own legal system.

In general terms, there are two main models to follow in the design of personal data protection laws: the European model and the US model.

8. Apply and update scientific, technical, and humanistic knowledge with a multidisciplinary approach

A competent workforce is essential to achieving the vision of high-quality PHC for all. Staff competence means that service providers have and demonstrate the "knowledge, skills, abilities, and competencies" to successfully and effectively deliver high-quality services.

The classification of quality of care is divided into technical and perceived. Technical quality includes care that meets standards and guidelines and is almost always learned during formal education or training. In contrast, perceived quality of care is measured from the perspective of individuals and includes their experience and satisfaction when interacting with staff.

Work motivation is defined as the degree of an individual's willingness to exert and maintain effort toward the organization's goals and is the result of a staff member's interactions with team members and other coworkers. It has been shown that staff motivation is closely related to burnout and satisfaction. Service providers who are more satisfied with their work tend to be more motivated, and burnout often occurs when they are overworked and dissatisfied. However, even if they are experiencing burnout, they can still be

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motivated if they are intrinsically committed and passionate about the work they do and the impact they make.

9. Promoting the rational use of health resources and timely referral between levels of care

The state and society are responsible for guaranteeing the right to health. The principle of justice is related to giving each person what they need. To this end, resources must be distributed appropriately and each patient must receive care in an appropriate institution, according to what they require for dignified health care.

This principle is fulfilled when the patient is treated fairly, is not denied information or service, is not imposed with illegitimate responsibility, and is not required to do more than is necessary (12). Healthcare professionals must balance the needs of patients and distribute resources ethically, avoiding unfair discrimination and considering the wishes of patients.

Now, speaking of distributive justice in a bioethical context, there are other normative principles to consider, as mentioned (13).

- **Equity.** This proposes the distribution of resources, goods, and services according to distributive justice, in accordance with the patient's needs, always governed by impartiality and guaranteeing the principle of opportunity.
- **Dignity.** It states that people should not be treated as objects, even after death.
- **Non-discrimination**. A principle linked to justice, whereby all people should have equal opportunities and rights. Healthcare should not be denied because of nationality, age, social contribution, or other factors.
- **Proportionality.** This refers to the relationship between means and predictable results. It employs the principles of beneficence and non-maleficence, creating a balance between the rights of the individual and obligations to society.

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- **Utility.** This considers both community and individual well-being in a moral context. It seeks the greatest overall benefit at the lowest acceptable cost.
- **Reciprocity.** This implies adequate and fair compensation for those who assume a greater moral risk than other people.
- **Solidarity.** This involves mutual support, recognizing the interdependence of individuals as moral agents. It is related to distributive justice and encompasses the relationship between the state and the individual.
- **Transparency.** This principle ensures distributive justice, where the allocation of resources must be public and clear, in order to guarantee justice and equity in procedures.

10. Offer equitable care to the public using health services

The 2008 report of the WHO Commission on Social Determinants of Health established that structural determinants and living conditions are the cause of much of the health inequality between and within countries. Evidence was gathered on the social determinants of health, particularly the distribution of power, income, and goods and services, as well as the circumstances surrounding people's lives, such as their access to health care, schooling, and education; their working and leisure conditions; and their housing and physical environment.

Three recommendations were made to address the problem:

1. Improve living conditions.
2. Combat the unequal distribution of power, money, and resources.
3. Measure the magnitude of the problem, analyze it, and evaluate the effects of interventions.

Interdisciplinary teams are key to addressing equity in each social context where healthcare is provided; medical care provided by doctors and nurses alone is not enough. The work of psychology and nutrition staff can have a significant impact on people's behavior and mental well-being. Social workers have a wide range of tools and knowledge for action in the areas of psychosocial factors and social cohesion.

Likewise, health promotion personnel and related actions are fundamental for the interrelation and attention to living and working conditions. Together with the interrelation of other sectors, such as education, security, and sanitation, these actions will improve the health levels of individuals, families, and communities.

Health promotion and disease prevention actions should be the first step and should be maintained throughout the provision of health services if the goal is to provide efficient and effective care, considering social determinants from a PHC approach, with a view to reducing inequality gaps in society.

11. Avoid stigmatization and all forms of discrimination

In the specific field of health, stigma is a well-documented global barrier to seeking health care (14), participating in care (15), and adhering to treatment (16) for a range of diseases (17,18,19).

Erving Goffman, a Canadian sociologist known for his seminal work *Stigma: Notes on the Management of Spoiled Identity* (1963), is considered one of the most prominent figures in the definition of stigma and is credited with initiating the scientific study of this phenomenon. He defines stigma as an attribute that profoundly discredits and reduces the bearer to a tainted and discounted person (20, p. 3). This definition is regularly cited by authors when explaining the concept of stigma, and it remains highly respected and dominant. In fact, his pioneering work is the most cited in this field, with 49,861 citations in Google Scholar as of December 9, 2022.

As current data, I share alarming figures on groups classified with labels of devaluation: according to the World Health Organization, as of 2022, it is estimated that, at any given time, one in five

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people live with poor mental health and one in eight people worldwide suffer from a mental disorder.

About stigma and discrimination in the workplace, discrimination against pregnant women with mental illness persists even though the Federal Labor Law, in its Title Five, establishes that women enjoy the same rights and have the same obligations as men. Specifically, Article 165 has as its fundamental purpose the protection of maternity. According to the Council to Prevent and Eliminate Discrimination in Mexico City (COPRED), dismissal due to pregnancy continues to be the leading cause of discrimination in our country, accounting for 39% of cases brought before that body in 2016.

The figures for adolescents in developing countries are alarming. For example, a sample of 100 pregnant adolescents or those who had recently had a baby reported significant levels of stress in 48%, sexual violence in 45%, physical violence in 36%, and perception of stigma related to pregnancy in 86%. In addition, suffering from high levels of depression and anxiety was a factor that increased stigma and violence, compared to women without affective symptoms (21).

Stigmatization affects those who suffer from it, as well as others. Research has shown that people related to stigmatized individuals (e.g., family members, friends, caregivers) are devalued simply because of their relationship with someone who is stigmatized (22,23,24). This situation is called courtesy stigma or stigma by association (23). Often, people try to hide their relationship with a stigmatized family member or encourage that member to hide their condition, which is detrimental to the psychological well-being of the stigmatized family member. Stigma by association even affects those who are not family members but who have developed social ties with stigmatized individuals, such as AIDS volunteers, mental health professionals, and more recently, healthcare personnel caring for people diagnosed with COVID-19.

About our current treatment of older adults, Mexico is gradually aging; the prevalence and tolerance of age discrimination is concerning. Miller mentioned more than fifty years ago that when older workers lose their jobs, they have more difficulty finding new opportunities compared to younger workers. Older workers have higher unemployment rates and longer periods of unemployment.

The vulnerability of older adults increases as they suffer from multiple illnesses as they age, requiring medical care from various specialists and, in some cases, one or more treatments, including polypharmacy. This has an impact on the economy, generating what finance specialists call "out-of-pocket expenses." This is without considering the perception of older adults that they increasingly need to use medications to maintain good health, which is and leads to another concept: "catastrophic expenditure," defined as spending more than 60% of personal income on the purchase of medications.

As a challenge for bioethics, the last element of the decalogue to prevent stigmatization or any type of discrimination takes up the idea of current thinkers such as Axel Honneth and Nancy Fraser. This idea applies to the defense of individuals and groups that have been stigmatized, seeking their recognition in political, social, economic, and cultural aspects.

Axel Honneth, a member of the so-called Frankfurt School, developed the theory of recognition in political philosophy and philosophy of law. Recognition, and specifically the struggle for recognition, were initially categories addressed by Hegel in his works *The System of Ethics and The Phenomenology of Spirit.*

The experience of injustice is part of the essence of being human; humiliation is the denial of recognition by others. For Honneth, the despised, humiliated, unrecognized man loses his integrity, his rights, his personal autonomy, and his moral autonomy. Honneth reconceptualizes, based on Hegel, the three spheres of recognition: love, law, and social solidarity.

To conclude, here are two quotes written by Nancy Fraser and Honneth (25).

> Justice requires both redistribution and recognition."
> "One becomes an individual subject only by recognizing another subject and being recognized by them."

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When a society broadens its framework of personal and social sensitivity to include new lifestyles or new rights for previously excluded groups or individuals, what Honneth calls "moral progress" manifests itself.

Conclusions

With the aim of elucidating the decision-making of health professionals in their everyday settings and based on the codes of ethics of each profession in these specific areas, the points of the Decalogue of Bioethics and Primary Health Care seek to confront a reductionist technocratic reality.

Reformulating Immanuel Kant's idea, current events question our scale of values, finding resounding repetitions of history with little tolerance for multicultural diversity.

The well-being of humanity and the planet we inhabit depends on our activities being driven by critical thinking that, rather than feeding biased big data, unifies the fundamental precept of the Universal Declaration of Human Rights: respect for dignity.

References

1. Gaceta del Semanario Judicial de la Federación. Libro 12, 2014; (1):1192.
2. Andersen M, Varga S, Folker A. On the Definition of Stigma. Journal of Evaluation in Clinical Practice. 2022; 28(5), 847-853. https://doi.org/10.1111/jep.13684
3. Diamond L, Alley, J. Rethinking Minority Stress: A Social Safety Perspective on the Health Effects of Stigma in Sexually-Diverse and Gender-diverse Populations. Neuroscience & Biobehavioral Reviews. 2022; 138:104720. https://doi.org/10.1016/j.neubiorev.2022.104720
4. Organización Panamericana de la Salud. Las funciones esenciales de la salud pública en las Américas. Una renovación para el siglo XXI. Marco conceptual y descripción. Washington; 2020.
5. Beauchamp T, Childress J. Principios de Ética Biomédica, Barcelona: Masson; 1999.
6. Sánchez JD, Cambil J, Villegas M, Luque F. Principle of patient autonomy. Reflections and bioethical conflicts. J Healthc Qual Res. 2020; 35(3):197-198. https://doi.org/10.1016/j.jhqr.2019.06.003

https://doi.org/10.36105/mye.2026v37n1.04

7. Altamirano P. El principio de autonomía. Anónimo. Experimento de Tuskegee. Universidad de Costa Rica; 2019.
8. Conbioética. Consentimiento informado. https://www.conbioetica-mexico.salud.gob.mx/interior/temasgeneral/consentimiento_informado.html
9. Martínez G, Goyri V. Consentimiento informado. Fundamentos y problemas de su aplicación práctica, México: UNAM, Instituto de Investigaciones Jurídicas y Programa Universitario de Bioética; 2017.
10. Congreso general de los Estados Unidos Mexicanos. 2024. Ley general para la inclusión de las personas con discapacidad. Ley general para la inclusión de las personas con discapacidad. https://www.diputados.gob.mx/LeyesBiblio/pdf/LGIPD.pdf
11. World Health Organization. Suicide Worldwide in 2019. https://www.paho.org/en/documents/suicide-worldwide-2019315
12. Ferro M, Molina-Rodríguez L, Rodríguez G. Las bioéticas y sus principios. Acta Odontológica venezolana. 2009; 47(2), 481–487. Available at: http://ve.scielo.org/scielo.php?script=sci_arttext&pid=S0001-63652009000200029&lng=es
13. Sinay J. Problemas éticos en la asignación de recursos escasos y cuidado intensivo en la atención de la pandemia por SARS-CoV-2 Una reflexión desde los principios, criterios, derechos y deberes. Acta médica colombiana; 2020.
14. Scott N, Crane M, Lafontaine M, Seale H, Currow D. El estigma como barrera para el diagnóstico del cáncer de pulmón: perspectivas del paciente y del médico general. Prim Health Care Res Dev. 2015; 16(06):618–622. https://doi.org/10.1017/S1463423615000043
15. Corrigan P, Watson A, Gracia G, Slopen N, Rasinski K, Hall L. Newspaper stories as measures of structural stigma. Psychiatr Serv. 2005 May; 56(5):551-6. https://doi.org/10.1176/appi.ps.56.5.551
16. Mahajan AP, Sayles JN, Patel VA, Remien RH, Sawires SR, Ortiz DJ, Szekeres G, Coates TJ. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS. 2008; 22 Suppl 2(Suppl 2):S67-79. https://doi.org/10.1097/01.aids.0000327438.13291.62
17. DiIorio C., Osborne P, Letz R, Henry T, Schomer D, Yeager K. The Association of Stigma with Self-management and Perceptions of Health Care among Adults with Epilepsy. Epilepsy & Behavior. 2003; 4(3), 259-267. https://doi.org/10.1016/S1525-5050(03)00103-3
18. Link B, Phelan J. Conceptualizando el estigma. Annu Rev Sociol. 2001; 27(1):363–385. https://doi.org/10.1146/annurev.soc.27.1.363
19. Hatzenbuehler M. ¿Cómo se infiltra el estigma de las minorías sexuales? Un marco de mediación psicológica. Psychol Bull. 2009; 135(5):707–730. https://doi.org/10.1037/a0016441
18. Goffman E. Stigma: Notes on the management of spoiled identity. Simon & Schuster; 1986.
19. Asiimwe R, Tseng CF, Murray SM, Ojuka JC, Arima EG, Familiar-Lopez I. Association of pregnancy-related stigma and intimate partner violence with anxiety and depression among adolescents. J Adolesc. 2022; 94(2):270-275. https://doi.org/10.1002/jad.12008

20. Hebl M, Mannix L. The Weight of Obesity in Evaluating Others: A Mere Proximity Effect. Personality and Social Psychology Bulletin. 2003; 29(1), 28-38. https://doi.org/10.1177/0146167202238369
21. Östman M, Kjellin L. Stigma by Association: Psychological Factors in Relatives of People with Mental Illness. British Journal of Psychiatry. 2002; 181(6), 494-498. https://doi.org/10.1192/bjp.181.6.494
24. Neuberg SL, Smith DM, Asher T. Por qué se estigmatiza: Hacia un marco biocultural. En: Heatherton TF, Kleck RE, Hebl MR, Hull JG. La psicología social del estigma. New York: Guilford Press; 2000.
25. Fraser N, Honneth A. ¿Redistribución o reconocimiento? Un debate político-filosófico. Morata; 2006.