A 25-year-old African-American man was diagnosed with HIV five years ago. After his initial diagnosis, he did not return for follow up care because he felt fine and did not see a reason to see the doctor. Also, he did not want to go to the HIV clinic and be recognized by any of his friends. He never sought treatment, but was eventually started on antiretrovirals when he developed a case of pneumonia. He was referred to the health department for case management services. During his application for these services, he brought in an application form to be completed by his health care provider. This form requested detailed medical information about his health status. In keeping with the policy of the clinic, a signed informed consent was requested for the release of information.

Several weeks later, the patient returned to the clinic, indignant, because his HIV status was disclosed in the form. After calming the patient down, it was discovered that he understood the informed consent to mean permission to say he had a medical condition, but not the details of his HIV status.

This case raises two points:

(a) The unique issues related to the continued stigma surrounding HIV/AIDS.

(b) The confusion about the purpose regarding informed consent.

Whetten-Goldstein et al. (2001) conducted a qualitative study of patients with HIV and their perceived breaches of confidentiality in hospitals, clinics, and health departments by health care professionals.

Those findings revealed that these patients perceived that breaches occurred by word of mouth, computers, facsimile and writing. Patients also indicated that sharing stigmatizing medical information among medical providers is a breach of confidence.

• Discuss what steps providers should employ to ensure patient confidentiality in each care setting.

• Discuss other Cultural Competence issues that may impact retention into care and treatment.