



HHS Public Access

Author manuscript

Ann Intern Med. Author manuscript; available in PMC 2024 July 26.

Published in final edited form as:

Ann Intern Med. 2022 August ; 175(8): 1199–1200. doi:10.7326/M22-0414.

Who Was She?

Jodian Pinkney, MD

Massachusetts General Hospital, Boston, Massachusetts

In the winter of 2021, while practicing as a first-year infectious disease fellow, I met a 30-year-old pregnant woman with severe COVID-19 pneumonia. She had migrated from the Caribbean just 6 months before, undoubtedly with all the hopes and dreams I myself carried not so long before that.

Shortly after our meeting, she died.

No one could have imagined this would be her fate. She was not vaccinated against COVID-19 because she was afraid of the potential harmful effects the vaccine could have on her fetus. Although her obstetrics team was able to deliver a healthy infant, the lasting pain of a child without their mother and a husband without his wife would never be undone.

In the United States, she would be classified as a non-Hispanic Black woman or an African American, just as I had been; however, these labels fail to capture so much of her identity. As I reflected on the questions this label left unanswered, I thought—who was she? What language did she speak? Why was she concerned about harmful effects? Was it related to previous adverse reactions to vaccines? What was her preferred source of information? How were vaccines viewed in her native country? Whom did she trust for vaccine advice? The answers to these questions might differ between Black women who were born in the United States and those who were not and may ultimately contribute to differences in vaccine hesitancy and vaccine uptake between them.

At the time of our encounter, *vaccine hesitancy*—defined as a delay or refusal of vaccination despite the availability of vaccine services—was a term I had become quite familiar with, both as an infectious disease fellow and a Black Jamaican immigrant of reproductive age. For me, the contrast between enthusiasm for COVID-19 vaccines at work and the lack thereof at home had been striking. I distinctly recall a conversation with my sister one afternoon where I described a feeling of living in two different worlds.

For me, transnational immigration, a conceptual model where immigrants tend to retain the cultural beliefs and practices of their native country while simultaneously adopting those of their new host country, partially defined what I was experiencing and explained how my experience could differ from that of a U.S.-born Black woman. For example, in my day-to-day life, relics of my native country persisted. I was likely to refer to soccer as “football,” have plantains for breakfast, and video chat with friends and family from my native country using WhatsApp instead of FaceTime. I also received daily messages from

Corresponding Author: Jodian Pinkney, MD; jpinkney@mgh.harvard.edu.

friends in my native country with content spanning conspiracy theories of depopulation, 5G technology, microchips, infertility, Big Pharma, and adverse effects. These were usually followed by the question, “Is this true?”

In this world, I was equally aware of current events happening in the Caribbean region and the United States. I kept my subscriptions to the Caribbean regional newspapers and media sites. I knew that vaccine uptake was disproportionately low in Jamaica and Haiti (the countries of origin of most non-U.S.-born Black Caribbean immigrants in the United States). At the time of my patient’s death, approximately 20% of Jamaicans and 1% of Haitians were fully vaccinated despite vaccine availability. I knew that they had access only to adenovirus vaccines, which initially came with a warning for people younger than 40 years and pregnant women. The situation in Haiti was even more complicated because they had been affected by a series of natural disasters and a presidential assassination that led to major disruptions in their vaccine supply chain and COVID-19 testing capacity. In addition, the low number of COVID-19 cases and deaths reported had the ability to influence the perceived risk for infection within their population. That risk was likely to increase if they immigrated to areas with higher COVID-19 case rates, such as the metropolitan locations in New York or Florida where many Caribbean immigrants reside. Who was communicating this increase to them? Who was helping them navigate the U.S. health care system?

Whenever a friend or family member from my native country came to me for vaccine advice, I would first listen. They would raise many questions for which I had no answers. First, my mom, who suffered such severe arm pain after receiving her second dose of the vaccine that she would cry herself to sleep for almost a month. She visited doctors and tried over-the-counter anti-inflammatory medications, but nothing worked. I could not advise her about the duration of this pain because my knowledge and the refrain that I often told others was simply “a few days.” One of my younger cousins developed a DVT after her first dose of an mRNA vaccine. My knowledge base in this instance stopped at “this was a very rare event.” She asked about timing of her second dose and her risk for future DVTs. Once again, I had no answers and directed her to her hematologist.

The questions kept coming: menstrual irregularities, previous vaccine reactions, mixing and matching different vaccines, alternative medicines. And I had no answers. Their experiences directly influenced their decision-making process, and I was happy to be a sounding board for their concerns. I thought back to my patient who died and wondered whether she had had a sounding board. Had there been a member of her health care team who she felt comfortable expressing her concerns to? I also reflected on the many individuals who had no such resource.

In my other world, as an infectious disease fellow in the United States, I was at the center of a community that had extremely positive views on vaccination. The only other specialty that arguably could rival us in this arena would be pediatrics. I had easy access to cutting-edge, reliable COVID-19 information. I also had access to world-class pundits who were able to simplify and clarify the rapidly changing landscape of COVID-19 vaccine eligibility, efficacy against variants, and adverse effects. At the hospital, I was able to feel the weight of COVID-19 cases on the health care system through the rapid breathing and worried

faces of my patients, recurring “hospital at capacity” e-mails, lugubrious relatives I spoke with on the phone who were unable to visit their loved ones, long waiting times for such less-used interpreter services as Haitian Creole and Amharic, and severity of COVID-19 in pregnant women who were not faring as well as their non-pregnant counterparts. The threat of COVID-19 was very real to me, and the benefits of COVID-19 vaccines were clear. However, despite all the available resources, I still found it challenging to “keep up” with COVID-19 vaccine-related information and understood why patients with less access to such resources would also have a hard time doing so.

Whenever a patient dies, one wonders whether anything could have been done differently to change the outcome. We think about the earliest possible intervention that could have changed the trajectory. In this case, one would say it was vaccination. But I challenge us to start with the question, “Who was she?”

To find out who she was involves the disaggregation of health data by birth. Using the lens of intersectionality—a framework where an individual’s identity consists of many strands, all interacting with each other to yield multiplicative effects—one appreciates that knowing someone’s country of origin may have been helpful in this case. A similar model has been proposed by the Asian & Pacific Islander American Health Forum. As the population of non-U.S.-born Black persons residing in this country grows, having disaggregated data available may help to connect them with culturally congruent resources. In the case of my patient, linkage to culturally appropriate resources may have been the start of a journey to address her vaccine-related fears—fears that ultimately contributed to her death.