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RESEARCH PAPER

Forging *compromiso* after the storm: activism as ethics of care among health care workers in Puerto Rico

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ABSTRACT

Puerto Rico was hit by a category 4 hurricane that severely damaged power, water, and communications systems on the 20th of September 2017. Based on 56 qualitative interviews, this article documents how health care workers created a new ethics of care after Hurricane Maria and engaged in novel forms of health activism to both repair past damage and imagine a different future. Many doctors, nurses, and other health care professionals went to work after the storm treating patients, fixing their workplaces, and resolving logistical problems. Health care workers responded emotionally to the event by finding meaning and purpose in their work, forging a sense of solidarity, and valuing their ability to help others. Our respondents used the term *compromiso* to describe their determination and sense of purpose, and we borrow this term to label the specific ethics of care generated from their experiences after Maria.

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Introduction

The young doctor greeted another patient in the hot, dimly lit schoolroom that had become his temporary clinic. Some of his patients suffered from chronic conditions like heart disease or diabetes that required medication. Others experienced injuries: sprains, blunt force traumas, cuts, panic attacks. He lost count of how many patients he had seen since the winds died down. Patients and friends stopped by his regular office, but there was no electricity there, and, nearly windowless, it was unserviceable. A sign at the medical office directed people to the improvised clinic at the school. There was no cell signal and no way to call an ambulance. For those in need of medical attention after Maria, the doctor who took up residence in a school building was their best option in this small northwestern town. He worked from sunrise to sunset without pay in a three-day long adrenaline rush. In the meantime, his mother cooked, cared for his young son, and listened to his stories when he came home at night.

On the 20th of September 2017, Puerto Rico was hit by a category 4 hurricane that severely damaged power, water, and communications systems across the archipelago. Many health care professionals went to work immediately after the storm treating patients, repairing their workplaces, and resolving logistical problems. Sheltering through the storm, confronting the extent of the damage, and living through the prolonged recovery period created a shared social experience for residents of Puerto Rico, even as those with more resources were better able to rebuild and recover.

This qualitative research project documents a strong sense of purpose and community orientation among medical professionals in Puerto Rico after Hurricane Maria. When we interviewed health

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Supplemental data for this article can be accessed here.

care workers, they described their *compromiso* or commitment to their care-giving work; that is, they expressed a sense of duty, solidarity, connection, and responsibility that helped them rise to the challenge of treating the sick and injured under sometimes harrowing conditions. We adopt the term *compromiso* to describe the ethics of care that health care workers created after the storm.

The concept 'ethics of care' comes from feminist philosophy and refers to an ethical orientation generated through the practice of caring for others (Tronto, 1993, pp. 126–7). This practice includes specific acts of caring, as well as the self-understanding and affective dispositions that caregivers inhabit through their work. In contrast to ethics that are codified and based in abstract moral principles, ethics of care emphasizes care work as contextual, rooted in interdependence, and responsive to the specific needs of those receiving care. Whereas professional codes of ethics like that of the American Medical Association (AMA) focus on doctor and patient autonomy, even listing the right to refuse care to patients as an ethical principle (AMA 2016), the practical ethics of care that interviewees described in Puerto Rico was community oriented, recognized that no one should be turned away or ignored, and involved much more than medical care – it also encompassed obtaining food, water, and other supplies for the population. In this article, we argue for the importance of attending to such practical ethics of care in the aftermath of disaster.

Background and literature review

Before Maria, the health care system was already straining under privatization and disinvestment in facilities and public medical education (Cabán, 2018; Mulligan, 2014; Rodríguez-Díaz, 2018). Major health reform in the US (Obamacare) in 2010 excluded Puerto Rico and thus exacerbated long-term financing issues (Portela & Sommers, 2015). Additionally, debt payments took priority over health system funding and workforce investments such as pensions and adequate staffing (LeBrón, 2016; Levis, 2016). Health care workers experienced two decades of falling or stagnant wages, loss of autonomy in clinical decision making due to the rise of managed care, and the imposition of an ethics of care based in economic principles of reducing system use, rather than maximizing public health (Mulligan, 2014; Rudowitz & Foutz, 2017). These pressures created widespread frustration and disillusionment, pushing many health care providers to migrate to the United States or elsewhere for work opportunities (Lerman, 2018; Parés Arroyo, 2018).

The population of Puerto Rico declined from almost 4 million in the early 2000s to approximately 3.2 million people in 2018 (Mora et al., 2018), with nearly 130,000 people leaving between July 2017 and July 2018 (Sutter, 2018). Large numbers of doctors and other medical professionals migrated, leaving patients with few options, particularly for specialized care (Parés Arroyo, 2018; Patron, 2017). Health care workers who remained in Puerto Rico operated in an environment shaped by structural neglect and colonial exploitation, a condition Hurricane Maria did not cause, but which she exacerbated.

The aftermath of Maria transformed people's relationship to state power, as the government failed to produce a coherent institutional response to the disaster, thus revealing the violence of colonialism and requiring painful sacrifices from the population (Weiss et al., 2018). The U.S. response to hurricanes in Texas and Florida was far quicker, mobilized more resources, and provided more relief funds than in Puerto Rico, even though Maria had a much higher mortality rate (Willison Charley et al., 2019). Puerto Rican health care providers who survived Hurricane Maria expressed higher rates of emotional distress than those who lived through Hurricane Harvey in Texas, also in 2017 (Powell et al., 2019).

In addition, Puerto Ricans were inaccurately portrayed as incapable of logistical planning or as subhuman by federal agencies and the Commonwealth government, and as abject or even as zombies in media accounts (Ficek, 2018, see also Lloréns, 2018a, 2018b). Against the preponderance of such representations, Puerto Ricans have 'bet on their own survival,' using mutual aid strategies to contend with the reality that 'only the people save the people' (Rodríguez Soto, 2020). The imperialist narrative of Puerto Rican incompetence and corruption obscures these efforts to care

for one another and to recover from the compounding disasters experienced since Maria (Garriga-López, 2020a). In this recovery process, Puerto Ricans across the islands and in the diaspora have strategized extensively, engaged in autonomous community organizing, and conducted what amounts to a grassroots disaster recovery (Garriga-López, 2019). The vacuum created by an ineffective and insensitive government response was filled by extended kinship and community networks, non-profits, and mutual aid as 'alternatives to hegemonic ways of knowing' and doing (Ortiz Torres, 2020). Health care workers created emergency infrastructures (Ficek, 2018), forged new practices to care for patients (Melin & Rodríguez-Díaz, 2018), and rebuilt the health care system after the storm.

Research on disasters has repeatedly shown that social solidarity increases and people tend to help one another (Oliver-Smith, 1999; Solnit, 2009). However, these feelings of social solidarity and new organizations are usually fleeting and rarely incorporated into the official disaster response efforts carried out by government and relief agencies (Drabek & McEntire, 2003; Stallings & Quarantelli, 1985; Twigg & Mosel, 2017). The disaster studies research predicts that the community-led projects that blossomed in Puerto Rico (Garriga-López, 2019) and the work of health care providers who assisted in recovery are but temporary responses to an emergency situation. However, the disaster studies research tends to underappreciate the affective dimension of disaster response (Barrios, 2017). In Solnit's survey of disaster response, she notes that emotions and solidarity are critical: 'that sense of immersion in the moment and solidarity with others caused by the rupture in everyday life, an emotion graver than happiness but deeply positive. We don't even have a language for this emotion in which the wonderful comes wrapped in the terrible, joy in sorrow, courage in fear.' (Solnit, 2009, p. 5). Joy in sorrow aptly describes how many residents of Puerto Rico felt as they worked together to care for the needs of their families, neighbors, and communities. In the years since Maria, ongoing community activism around public health issues has become part of the broader movement for self-determination and decolonization (Rodríguez-Díaz, 2020).

The concept of ethics of care helps us theorize the moral, affective, and political dimensions of these emergent social practices of caring. Within feminist philosophy, an ethics of care refers to ethical actions that are intersubjective and grounded in reciprocity and mutual obligations to one another rather than an abstract set of principles (Larrabee, 1993). The term was introduced by psychologist Carol Gilligan (1982) to counter the then canonical view within developmental psychology that women's moral development was inferior to men's because women were insufficiently autonomous and less interested in abstract notions of justice. Gilligan argued that women were not deficient, just different; they exhibited an 'ethic of care' grounded in responsibility, interdependence, and relationship to others.

Gilligan's intervention generated many critiques (Larrabee, 1993). Anthropologists, among others, have found the concept useful. They have also described how its universalizing assumptions about gender can mask differences among women (Stack, 1993) and naturalize social roles that equate womanhood or femininity with caretaking. The binary framework of men versus women and justice versus care also reifies a dimorphous sex/gender system, thus limiting the analysis. More recent uses of the term by philosophers argue against the notion of a women's morality (Tronto, 1993) and take a 'critical speculative' approach to care that encompasses broader ecological concerns (Puig de la Bellacasa, 2017). Although it is difficult to disentangle from stereotypical assumptions about gender roles and behaviors, the concept of an 'ethics of care' continues to hold explanatory potential and political relevance because through everyday acts and relations of care, people create the vernacular ethics that sustain life and transform social worlds.

Anthropologists have demonstrated that what motivates and sustains caregivers to attend to the sick and injured is always culturally and historically specific. Ethnographic work with professional caregivers complicates the notion of care as intrinsically generous, oriented towards mutuality and responsibility, and positive. Professional care work can be these things, but it can also be highly technocratic, organized by bureaucratic imperatives (Foner, 1994), indifferent or cruel, and driven by financial concerns.

Research on non-physician providers such as nurses and home health aides demonstrates that care is a form of work that ties into systems of kinship and gendered/racialized economies (Amrith, 2017; Boris & Parreñas, 2010; Buch, 2018; Stacey, 2011). Rather than one ethics of care common to all women, ethnographic studies of professional caregivers have shown multiple, situated ethics of care that require elaboration and contextualization. Gendered and racialized expectations about caregiving, the economic and bureaucratic organization of care, personal biography, experiences of racism and class discrimination, availability of resources, and level of professional training are important social variables that significantly shape the ethics of care salient in any particular setting. In our research in Puerto Rico, *compromiso* was the most common, but not the only ethics of care style that health care workers described; they also reported feeling detachment and burnout, and some approached caregiving through the neoliberal frame of prudential and efficient patient management.

Thinking through and with care has become an important approach to theorizing our social obligations to each other, as well as the unequal ways in which individuals are called on to assume caregiving responsibilities. This project takes inspiration from the work of those who argue that care is a radical act under conditions of intense racialized and structural violence (Kawehipuaakahaopulani et al., 2020; see also Davis, 2016; Smith, 2016). Sharpe elaborates this project in an essay that makes reference to community activism after Hurricane Maria as a form of care. She links the brutality faced by Maria survivors to longer histories of racial capitalism and colonial extraction that have always been countered by everyday practices of survival: 'With the ordinary note of care – living as we do in the hold, in the wake, the deportation flight-as-slave ship, in this longue durée of Atlantic chattel slavery – I wanted to think, without proscription, an ethics of care as we work toward making a new world' (Sharpe, 2018, p. 175). This literature considers how people continue to care for each other and sustain life despite persistent violence. Hurricane Maria and its aftermath fostered the emergence of a new approach to care – one rooted in mutuality, reciprocity, commonality of struggle (Atiles-Osoria, 2020), multiple solidarities (Santiago-Ortiz & Meléndez-Badillo, 2019), responsibility, a sense of connection, and hope for a better world to come.

Methods

The primary data collection method used in this study was semi-structured interviews. The research question was: What ethics of care were forged by health care workers and how do these ethics of care shape the work of recovery and enable resilience? We define health care workers broadly to include clinicians (doctors, nurses, dentists, pharmacists, etc.); office support staff; public health practitioners; and health care administrators. This broad definition ensures that participants reflect a variety of class positions and educational backgrounds. We focus on health care workers because of the acute need for medical services after the hurricane and their role as first responders. Health care workers also carry some of the collective memory of the lethality of the event which has not been officially recognized, but which catalyzed public mourning through testimonies, art installations, protests, and the ubiquitous '4645,' signifying the estimated number who died.[1]

Interviews were conducted in Spanish (48) and English (8). Interviews covered pre-defined topics for comparability. The interviews covered topics such as professional formation and motivations for pursuing care work, the experience of sheltering through the storm, short term needs after the storm, and challenges to longer term health system strengthening and rebuilding. The flexibility of a semi-structured format was ideal for eliciting open-ended and individualized answers regarding how health care workers experienced and responded to the storm.

Over eight weeks of non-continuous fieldwork between July 2018 and July 2019, the two co-PIs collaborated on this project along with six undergraduate students. Mulligan conducted pilot interviews in July of 2018 with 14 respondents. The co-PIs trained four undergraduate students in ethnographic methods in the fall semester of 2018. In December 2018, the co-PIs and the students traveled to Puerto Rico and conducted 22 interviews. In July of 2019, both co-PIs returned to Puerto Rico and conducted the remaining interviews, bringing the project to 56 participants. Student

researchers assisted with coding and analyzing the interviews in 2019–2020. Consistency in coding was achieved through weekly meetings to review one another's work and discuss discrepancies.

Initial respondents were recruited from professional networks and associations. Additional respondents were recruited purposively to include municipalities outside of San Juan and a broader range of experience. The final sample is more than half from the San Juan Metropolitan Area and the rest from other parts of the island, including the mountains, west coast, and south. Supplementary Table 1 describes the composition of the study sample.

Findings

Like other residents of Puerto Rico, health care workers sheltered through the storm and emerged from their homes and workplaces on Thursday, September 21st, 2017 to find their surroundings transformed. The landscape was muddy brown and devoid of leaves in the usually verdant islands. Trees and personal belongings were scattered everywhere. Roads were washed out or blocked by debris. Water rose to record heights in flood plains and the rain continued for several days. Zinc roofs had lifted completely off homes, windows and sliding doors had blown out, and the sealant on many roofs and windows had been compromised. Even so, many of the health workers we interviewed described minimal damage at their residences and stated that their priority was to return to work as soon as possible. Health care workers were more likely to live in cement homes and have undertaken some hurricane preparedness like obtaining storm shutters, stocking up on supplies, or purchasing a generator. But they faced a collapsed communications infrastructure, no electricity, impassable roads, and an impending shortage of supplies including food, water, and fuel.

Health care workers responded to the challenge by resolving supply issues (procuring fuel, generators, food, medication, coordinating transfers, etc.); relocating or adjusting clinics and hospitals (putting up tents, using mobile clinics, going into the community, operating only during daylight hours); and prioritizing their work over family, repairing their own residences, and even self-care. Health care workers responded emotionally to the event by finding meaning and purpose in their work, forging a sense of togetherness and community, and valuing their ability to help others. In early interviews, though we asked respondents to reflect on 'resilience' and recovery, health care workers gravitated instead to the term *compromiso* to describe their determination, solidarity, and sense of purpose. We thus borrow the term *compromiso* from our respondents to label the specific ethics of care style forged in their experiences after Maria.[2] Below, we give examples of how project participants defined *compromiso* and identify three aspects: its link to meaningful labor; community solidarity; and connection to Puerto Rico.

Compromiso defined

A 54-year-old administrator with a PhD who ran a program for people with HIV defined c*ompromiso* by describing how her co-workers shared food, water, and other necessities with one another after the storm. The hospital in the south of the island suffered major structural damage and most acute patients had to be transferred to other facilities. However, the transfers took weeks to complete and in the interim the staff cared for the patients as best they could. She described the environment as one with,

> A lot of love and a lot of *compromiso* in order to help the population and ourselves … In our *compromiso* we create a relation that goes beyond work. It's about helping one another out and serving the patients. It's about more than work, we consider ourselves family. (…) We came here to work, to help, this isn't just about collecting a paycheck. What matters to us is the life of the patient. We gave our all for the patients, and when I talk about it, I get emotional because it was so hard.

She teared up recounting what the hospital was like in those days. The emotional resonance was strong for many respondents; others described getting goosebumps or having their hair stand on

end as they answered our questions. This strong emotion was also a source of strength. The administrator felt she could handle the challenges, did not get tired, and did not want to stop working during the crisis. *Compromiso* was related to her professional identity, but importantly went beyond work, expressed love, and brought patients and staff together. This is the everyday ethical practice that guided care work after the storm.

A 72-year-old health center director from the mountainous interior recalled how her staff reported to work immediately after the storm. Even as the health center remained closed, employees went out to the surrounding communities to provide services like vaccinations and insulin regardless of whether people were patients of her clinic or not.

> It didn't matter who the person was, because this wasn't just for our patients, it was for whoever was in need, we didn't distinguish between people. Everyone had the same opportunity to seek services because we were all in the same situation. At no time did we say, "No, we can't do this." It was always, "Yes, let's help."

This quote captures the sense of hope that providers brought to their work. It also shows how differences between patients and staff were bridged as people saw themselves in similar situations. Others also talked about *compromiso* in terms of love, like for example, this HIV services provider,

> We are strong and we love our patients, because when one is *comprometido* [having *compromiso*] with your people, you will do every last thing for them. This moves me. They become family, and you know that the majority of our patients are people who have suffered rejection from their own families and from society, and when you are their only help in those moments it is moving and gratifying.

It is notable that this provider was specifically concerned with the well-being of HIV positive people who tend to have less familial support due to stigma. This shows self-awareness of the significance of the provider's own role as a key source of stability in the person's life, as well as an enactment of queer solidarity, when later in the interview she explicitly linked her lesbian identity to her commitment to caring for HIV positive people.

The main qualities that interviewees identified with *compromiso* were love, commitment, and strong connection to others. This practical ethics far exceeds the professional codes that guide clinicians which are more individualistic and circumscribed in character.

Compromiso aspect 1: meaningful labor

A physician and educator at the University of Puerto Rico's School of Medicine in San Juan described how the resourcefulness of her colleagues and staff allowed her department to manage under emergency conditions.

> I'm talking more about physicians because that's the area where I was most involved in helping. But nurses, therapists, and the rest of the staff lived the same thing. People here are used to giving 100%, but I think they gave 200%. They did.

This sense of working beyond one's duties and going the extra mile was common in accounts of *compromiso*. Rather than feeling resentful or overtaxed (which has been found in other studies of caregivers), health care workers in Puerto Rico described finding meaning and purpose in their work.

A community health worker from the south said that the director of the health center where he worked gave employees the choice to either leave or stay and pitch in after the storm. What was coming would be serious, the director warned. Employees could leave without negative repercussions. 'He prepared us and we knew there would be no regular hours, no excuses, and no tears. Nobody had to join in, but every single person did. The work was incredible, it was "*brutal*" (slang), it was really good.' These testimonies show that many providers chose to stay in Puerto Rico through the storm and afterwards worked together to mitigate the effects of the disaster on health care delivery.

A Clinical Service Coordinator admired the dedication of his colleagues who showed up to work in uniform after the hurricane and were able to coordinate shifts so that patient care would be uninterrupted. Workers did not have electricity or clean water at their own homes. However, they

had such pride in their work that they figured out ways to come dressed in their uniform. 'It was like picture day at school,' he said.

Clearly, *compromiso* entails a strong commitment to work and fulfilling one's responsibilities to patients and co-workers. Often, this meant that health care work was prioritized over other responsibilities in the person's life, which was especially difficult for those with fewer resources and multiple caretaking roles at home and at work.

Compromiso aspect 2: community solidarity

Beyond feeling a responsibility to continue providing care, many health care workers expressed a sense of connection to and orientation towards others in their community, as well as a shared sense of being in this together. A nurse at a primary care office in San Juan explained that she got back to work almost immediately after the storm, but she also helped neighbors. One neighbor had a hard time walking and could not cook, so the nurse brought her food every day. When tickets for free groceries were distributed in the neighborhood by community groups, the nurse gave her neighbor her own ticket.

Health workers supported their neighbors and neighbors also supported health workers. At the primary care office where this nurse worked, one neighbor helped out by running a power line from their personal generator to the upstairs office above so that patients could be seen. It was hot and they couldn't run the air conditioner, the nurse explained, but they were able to renew prescriptions, attend to minor injuries, and follow up with patients who had chronic conditions.

A public health professor who participated in and helped to organize health brigades discussed the sense of community he felt.

> I used to be that typical professor who would give classes and be involved in various projects. I have to confess that my community work was very limited. (. . .) And Maria completely changed that for me. Now I'm much more focused on community work and I try to do as much as I can. Sure, it's always a challenge when I have to be here (at the university) stuck in meetings and other things, but I have realized that if the university wants to really be relevant, we have to get out in the streets.

Eighteen months after the storm, this professor was still organizing health brigades and deeply engaged in community work, where he found new purpose and meaning. Boundaries between health care providers and communities broke down for many after the storm and this connection to the community has continued to be important as Puerto Rico has confronted additional disasters, including earthquakes and COVID-19

Compromiso aspect 3: connection to Puerto Rico

For some respondents, the shared sense of community was expressed in cultural terms. It wasn't just that people came together after the hurricane, but that this coming together fostered a sense of belonging that was meaningful and deeply held.

An emergency room physician in a public hospital near San Juan commented on how hospital employees–from doctors, to the nursing staff, to the security guards–they all rolled their sleeves up and worked. Absenteeism was not a problem. Without food, without water, they went on. They had children at home in the care of grandparents and still they came to work. One nurse could not find her daughter; with no phone service she couldn't talk to her. She came to work in tears, but still she came. People had every excuse to stay home and they didn't. 'The truth is for us, this is our custom. This culture of helping comes to the fore and we are all very happy when it does.'

The owner of a laboratory in the central mountainous region of Puerto Rico described the link between *compromiso* and a sense of unity as a people.

> The *compromiso* at the hospitals was huge, seriously because here just as in the U.S. hospitals are competitors but they all came together to help one another and look for solutions. What can you do? Who can you take that

> I can't? … Things happened that we had never imagined and we all went to work, (a la obra) and that's what brought us together as a people (pueblo) and we saw ourselves as a people who could unite and that together we are very strong. … I learned to be more sensitive, more *comprometido* with my island, *comprometido* with the island in the sense of listening to everyone, of not feeling like I am me and nothing else.

The laboratory owner went on to comment about the protests that had been occurring as part of the Ricky Renuncia campaign. Protesters expressed outrage at the government response to Maria and the mishandling of relief efforts. When electronic chat transcripts were released in 2019, the public learned that the governor and his inner circle made light of the situation from the comfort of their air-conditioned offices while most of the population languished without electricity, potable water, or telecommunications (García-Quijano & Lloréns, 2019). The laboratory owner we interviewed in July 2019 (as anti-government protests paralyzed the country) contrasted the sense of purpose and togetherness that was forged after Maria with growing frustration over the mismanagement of the recovery, the lack of federal financial support, and the 'vultures who were feasting' on the chaos created by Maria. 'I have felt it in these past days even more because now we won't tolerate it anymore.' The laboratory owner's comments illustrated how *compromiso* connects to culture and in turn to politics, an observation that complements other analyses of the protests that emphasize how government officials violated 'shared core cultural values of *respeto, compasión, and humildad*' [respect, compassion and humility] (García-Quijano & Lloréns, 2019).

Boundaries of compromiso

While *compromiso* was important to and mentioned by the majority of our respondents, it was not the only ethic of care in circulation after Hurricane Maria and it was not always possible or desirable for individuals to exhibit *compromiso*. In this section we describe criticisms of and resistance to *compromiso*. Some respondents expressed feelings of burnout, conflicts with other responsibilities, and feeling too put upon by their supervisors without adequate support. Gender and class were important in explaining different interactions with this new ethics of care. Those with more care giving responsibilities in their families (often women) expressed more conflicts around *compromiso*. Those with higher socioeconomic status (MD, or PhD levels, higher income, more job autonomy) were more likely to express high levels of *compromiso*. Workplace policies such as rotating schedules, collecting information about worker's commutes, limited hours, and providing support to workers such as water, food, and cash payments (because access to electronic bank accounts was very limited) went a long way towards fostering conditions for *compromiso*. A nurse from a specialty medical office in the interior of the island described difficulties juggling her competing priorities that included caring for her elderly parents, re-opening the medical office, repairing her home, and contributing to her community by working with her church

> I had many responsibilities, I felt a lot of responsibility to collaborate, to help my community. But with my parents what we had to do was divide the days, on Monday my sister went, on Tuesday someone else—we realized that they needed things like food and there was no way to communicate. And so we had to organize the family to make sure that my parents were okay.

Once the power came back on at her parents' house, she felt more like things were getting back to normal. Considerable disruptions persisted at the medical office twenty-one months after the storm, including not having internet access, which limited their ability to use medical records and billing systems. However, the most challenging disruptions that Maria created were within her family.

A psychologist from the west discussed feeling overwhelmed when working at a shelter to hand out supplies and food. She tried to provide psychological help to a woman who arrived at the shelter covered in mud from trying to clean her home. The psychologist felt like she was following a script, but could not really be available for anything more than validating what the woman said. 'It was so draining and overwhelming' the psychologist explained. She wanted to be present and offer help,

but was concerned about her family who lived an hour away. She had to rely on very basic tools in the face of so much extreme need.

Finally, a medical office receptionist in San Juan spoke of having to go back to work a week after the storm when she still had to repair her apartment. With no power in the city and a curfew in place, she did not feel safe driving home after work.

> The office filled up with people, and it was horrible because we couldn't leave until it was dark. I mean, I understand, people needed their medications, their insulin. People would come in crying, one person covered in burns from a generator that exploded. We saw many things, it was impressive. … Leaving the office, I would walk with a flashlight, and carefully because you couldn't see anything, it was so dark … I walked with the flashlight because you never know when a bicycle, or a scooter would pass, or what you might find, truly it was difficult, it was too much. I asked the doctor. Please, we leave by ourselves and it's dangerous. Even though the security guard stayed late, it's not like he can follow me all the way home.

For this single woman in her late 20s who lived alone, leaving work after dark during a curfew put her in danger and she felt imposed upon.

As these examples show, people experienced role conflict as a result of multiple caregiving roles and juggled competing solidarities between primary attachments to kin, work, and other community groups (such as churches). Not feeling personally cared for was an important factor limiting *compromiso*. Even people who identified with *compromiso* and talked about its importance were not always in a position to enact it. The varying strength and balance of the three aspects of *compromiso* we identified – meaningful labor, community solidarity, and sense of connection to Puerto Rico – also played an important role.

Conclusion

In this article, we show how everyday acts of caring for others generated solidarity and a sense of efficacy that guided the recovery process in health care contexts. An ethics of care, *compromiso*, nourished and complemented other forms of solidarity and mutual aid that flourished after the storm, catalysing broader political changes in Puerto Rico. Our novel application of feminist theory links ethics of care to the analysis of disaster response and advances the understanding of recovery as a technical, social, and affective process. We pay attention to the ways that everyday acts of care reflect longstanding commitments while shaping new ethical practices and political dispositions. Our findings can contribute to developing response efforts and medical training that recognize the wisdom and more fully support the emotional and affective needs of health care workers.

Health care workers brought into being a different future through their provision of care with *compromiso*. The particular ethics of care that emerged after Maria shows how intimate and interpersonal acts of care can produce broader political transformation in concert with other forms of resistance. Since 2019, Puerto Rico has experienced at least two additional disasters: the earthquake swarm that began in December 2019 and the COVID-19 pandemic. It is still unclear if an ethics of care that involved finding meaning and dedication to work, forging solidarity with the broader community, and leveraging a cultural connection to Puerto Rico will help health care workers navigate the daily challenges of living in these very prolonged emergency conditions.

It is possible that some of the boundaries of *compromiso* will fray, especially for those who have other caregiving responsibilities or who do not feel protected themselves at work like the medical secretary who feared her commute home. There are also fundamental issues with how sustainable *compromiso* is in the long run. The extraordinary dedication to work is possible under emergency conditions, but what happens when emergencies begin to compound upon one another? For how long can health care workers fill the gaps created by a lack of effective government planning and response? Workplace policies such as rotating schedules, collecting information about worker's commutes, limited hours, and providing support to workers such as water, food, and cash payments (because access to electronic bank accounts was very limited) could foster conditions for

compromiso. However, in the long run, care institutions need to create conditions that don't require health care workers to sacrifice themselves and their other relations of care.

In this article, we join those who have argued for a liberatory ethics of care as a model for health care professionals interested in 'societal transformation' (Dutt & Kohfeldt, 2018). Rather than think of this ethics of care as a substitute for the formal, codified professional ethics that normatively guide the practice of clinical care, we see the renewed focus and connection to *compromiso* as indicative of a flourishing of practical, everyday approaches to care that just might produce a different future. In a broader sense, a social ethics of care is also present in autonomous community organizing and mutual aid as 'practices of anticipatory freedom' that have been fundamental to the disaster recovery process (Garriga-López, 2020b). As Puerto Rico continues to face emergencies and compounding disasters in the extended recovery period after Hurricane Maria, the practical skills, affective dispositions, and ethical orientations of health care providers as first responders and community members with *compromiso* will continue to shape and influence the flourishing of life in Puerto Rico.

Notes

1. The figure 4645 comes from an article published by Kishore and colleagues in the New England Journal of Medicine. This mortality estimate is based on results of a representative household survey. When published, the official mortality count was 64. Another major study published by the George Washington University in collaboration with the University of Puerto Rico School of Public Health estimated 2,975 deaths (The George Washington University Milkin Institute, School of Public Health [GW SPH], 2018). The exact number of people who died due to Maria is still unknown.
2. Compromiso is a term that was already in use before Hurricane Maria. However, we argue that it accrued a new relevance and importance after the storm. We are currently gathering data on how health care workers talked about their professional identities on social media before Hurricane Maria and so hope to have more to say about past uses of the term in future publications.

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