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DOI:
10.1007/s10691-021-09465-3

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (Harvard):
Krajewska, A 2021, 'Rupture and continuity: abortion, the medical profession, and the transitional state—a Polish case study', *Feminist Legal Studies*, vol. 29, no. 3, pp. 323-350. https://doi.org/10.1007/s10691-021-09465-3

Feminist Legal Studies
https://doi.org/10.1007/s10691-021-09465-3

Rupture and Continuity: Abortion, the Medical Profession, and the Transitional State—A Polish Case Study

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Accepted: 5 May 2021

Abstract

Taking Poland as a case study, this article examines the sociological and historical-institutional factors that determine the relationship between the process of medical professionalisation and reproductive rights in transitional societies. Focusing on three periods in Polish history, (a) Partition era (1772–1918), (b) the Second Polish Republic (1918–1939), and (c) the post-war period (1945–1989), it identifies ruptures and continuities that have shaped the development of the Polish medical profession and its attitude towards abortion care today. Using insights from feminist historical institutionalism, abortion studies, and the sociology of professions, the article applies the concept of 'dialectical transformations' to explain institutional and policy reproduction and change over time. It shows how professional and legal institutions are often transferred from one systemic context to another by individuals or organisations whose positions move from opposition to dominance. Understanding such processes is especially important in light of the retrenchment of reproductive rights across the globe.

Keywords Abortion · Historical institutionalism · Poland · Sociology of professions · The medical profession · Transitional society

Introduction

On 22 October 2020 the Polish Constitutional Tribunal issued a judgment (K1/20), which amounts to a de facto ban on access to lawful abortion in Poland (Krajewska 2020a). Despite the unprecedented mobilisation of large parts of Polish society as a result of this judgment, human rights organisations have reported that it has already had a chilling effect on the (in any case very limited) provision of abortion services (Polish Ombudsman 2020). The rapidly deteriorating situation of women in Poland has caused alarm around the world. At the same time, the protests and women's

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Published online: 26 June 2021

strikes form an integral part of global feminist mobilisation more generally (Bhattacharya 2017; Fletcher 2018; Kubisa and Rakowska 2018; Korolczuk 2020; Rodak 2020; Fillieule and Broqua 2020; Daby and Moseley 2021).

A lot has been written about the development of reproductive rights in Eastern Europe (Heitlinger 1987; Einhorn 1993; Kligman 1998; Gal and Kligman 2000; David 1999; Drezgic 2010). There are two main reasons why this region is particularly illuminating and important in analysis of reproductive rights. First, it is important because it throws light on the construction of reproductive rights in a distinctive (long) transitional post-imperial[1] socio-political space, marked by unusually contingent and frequently interrupted formative trajectories. Second, it is important because it allows us to observe the linkages between processes of democratic and socio-economic transition and the construction and retrenchment of reproductive rights, which became particularly acute in countries like Poland or Russia. This retrenchment is commonly attributed to the hegemonic position of religious organisations, traditional social structures, and the rise of Conservative parties after 1989 (Jankowska 1991; Fuszara 1991; Hoff 1994; Kulczycki 1995; Titkow 1999; Zielinska 2000; Graff 2008; Fidelis 2010; Mishtal 2015; Kuhar 2015; Rosenfeld and Mancini 2018). Despite such importance, the deep structures that shape these processes remain relatively unexplored. In particular, still relatively little is known about the role of the medical profession in shaping the laws and policies concerning sexuality and reproduction (Malarewicz and Sola 2011; De Zordo and Mishtal 2011; Kuźma-Markowska 2017; Ignaciuk 2021). There is insufficient analysis of the process of medical professionalisation, identified in Anglo-American literature as a crucial element in the development of sexual and reproductive rights. Understanding these factors that shape the operation of such rights on the ground is especially important in the current political situation, in which both the rule of law and women's reproductive rights in Eastern Europe and many states across the globe are under attack (Girard 2017; Nash et al. 2018; Vida 2019).

This article aims to examine the sociological and historical institutional factors that have determined the relationship between the behaviour of medical professionals and reproductive rights in (late-)transitional states. In particular, it focuses on (a)

[1] The description of modern Polish society as 'post-colonial' remains controversial, especially in light of the use of this term by the political right and right-leaning scholars (see Cavanagh 2004; Thompson 2010; Snochowska-Gonzalez 2012). Yet, there are important reasons why Poland can be characterised as a post-imperial state. A detailed discussion of this problem cannot be undertaken here. However, the use of the term 'post-imperial space' to describe Poland requires some explanation. While it was itself an empire in the fifteenth and sixteenth centuries, Poland was occupied and partitioned by Prussia, and by the emerging Russian and Habsburg empires between 1772 and 1795. Following this, Poland disappeared as a sovereign political entity until 1918. During this period, the occupying empires established governments enforcing elements of indirect rule, the nature of which changed over time, introduced tiered citizenship regimes, and imposed external legal systems. They also engaged in prolonged and systematic extraction of wealth, including natural resources and human labour (Roeder 2007; Manby 2009). Importantly, some Polish elites actively participated in sustaining the system of oppression and exploitation. These processes have had a lasting impact on modern Polish society (Mayblin et al. 2016). It is often argued that the Soviet influence after World War II could also be seen as part of the same process of colonisation. However, there is sufficient evidence to question such conceptualisation (see Kościańska and Owcarzak 2009; Kołodziejczyk and Sandru 2012).

ways in which patterns of individual and collective behaviour and the legal agency of doctors change over time in response to systemic transformations, and (b) how, in turn, these changes affect reproductive rights. As a case study, the article analyses the connection between the process of medical professionalisation—understood as increasing specialisation and attainment of regulatory professional autonomy—and the development of abortion law in Poland. The wider explanatory significance of the Polish case study is linked to the country's numerous experiences of systemic transformation, to its specific pattern of medical professionalisation, and to the fact that it has experienced an unusual, non-linear development of reproductive rights. While under the Socialist regime abortion was legal and widely available for almost 40 years, the political and socio-economic transition, formally initiated in 1989, gave rise to one of the most restrictive abortion regimes in Europe. Importantly, the majority of medical professionals conformed—at least officially—to the conservative line pursued by official medical organisations, which played and continue to play an active role in the restrictive law reforms. At the same time, Poland has been considered an exemplary case of democratisation and socio-economic transition. Consequently, analysis of the historical development of the Polish medical profession provides distinctive and important insights into the ways in which the medical profession determines the trajectories of reproductive rights in other transitional (democratising) societies. Moreover, the study of reproductive rights over time reveals an additional layer of complexity in the processes of transition. Finally, it directs attention to parallel processes in other transitional societies in Latin and South America, Africa, and Europe (Htun 2003; Elgar 2014; Bergallo 2014; Blofield and Ewig 2017; Enright et al. 2017; Havelková 2017; Rosario and Gianella 2019; Roth 2020).

A Threefold Theoretical Framework

The argument presented in this article is set within a theoretical framework based on three distinct yet interrelated bodies of literature: feminist critique of historical institutionalism, sociological and historical studies of abortion, and the sociology of professions.

First, the article extends feminist historical institutional studies (Mackay et al. 2009; Krook and Mackay 2011), which show how seemingly neutral institutional processes and practices are "embedded in hidden norms and values, privileging certain groups over others" (Kenny and MacKay 2009, 274). It identifies and examines 'formative moments' (Rothstein 1992, 174) of legal and institutional flux, which led to dramatic changes in the organisation of healthcare and, subsequently, to reform of laws regulating access to abortion. It challenges the more established assumption that such 'critical junctures' (Peters et al. 2005; Capoccia 2016) can be easily superimposed onto "critical phases" (Polanyi 1944, 163) in history caused by exogenous shocks in Polish society over the years. Distinctively, the article presents a more gradual conception of institutional transformation (Hall 2010, 205; Pierson 2004, 55; Mahoney and Thelen 2010), demonstrating that even in transitional societies punctuated by systemic ruptures, remnants of older institutional structures do

not entirely vanish. It shows that, when systemic changes take place, some institutions remain dormant or suspended. Values embedded in these institutions may become latent but they never fully disappear, and they are often transferred from one systemic context to another by individuals or organisations whose positions move from opposition to dominance. Consequently, the article argues that the development of Polish abortion law constitutes an example of what should be called *dialectical transformations*. This conceptualisation allows us to explain the complex processes of sexual and reproductive rights formation in transitional societies. It goes beyond the mainstream theories that focus solely on contemporary socio-political tensions and conflicts.

Additionally, the article tests in the Polish context the findings of Anglo-American studies of abortion, which demonstrated how over the centuries medical organisations utilised abortion law to strengthen their professional autonomy and economic power (Mohr 1978; Luker 1984; Keown 1988; Joffe 1995; Petchesky 1997; Reagan 1997; Sheldon 1997; Solinger 1998; Beckett and Hoffman 2005; Thomson 2013; McGuinness and Thomson 2015; Sheldon and Kaye 2020). The article demonstrates, similarly, that the majority of Polish physicians treated reproductive rights instrumentally in pursuit of such aims. As such, it expands on a small number of Polish studies, which have demonstrated how physicians, especially gynaecologists, involved in the provision of abortion services, used abortion law to gain competitive advantage over midwives and traditional healers and strengthen their societal position (Kuźma-Markowska 2009, 2017; Klich-Kluczewska 2012a, b). In this respect, the article challenges sociological studies of both abortion laws and professions, which highlight the distinct patterns of professionalisation and abortion law formation in Central and Eastern Europe (Cocks and Jarausch 1990; Burrage and Torstendahl 1990; Balzer 1996; Kovács 1994; Sciulli 2009).

At the same time, the article utilises insights from the sociology of professions to explain why the medical profession in Poland was often complicit in the frequent changes in abortion law or showed little resistance to abortion reforms. In particular, it draws directly on studies of professions in Central and Eastern Europe, which demonstrated that professions in the region were particularly "vulnerable to the changing ideological priorities of different regimes in the twentieth century" (Cocks and Jarausch 1990, 20). This, it is claimed, is due to the fact that they developed in a close institutional and regulatory proximity to the state through "professionalisation from above" (Siegrist 1990, 177–178). The article argues that the Polish medical profession displayed similar vulnerability, while at the same time retaining its privileged societal position through different transitions. The combination of these factors explains why the majority of physicians embraced the changes in abortion law after 1989. Consequently, the relationship between professionalisation and abortion law in Poland is much more complex than in Western Europe and beyond. The article addresses an important gap in the literature on the sociology of professions, in which sexual and reproductive rights generally and the Polish case study specifically remain oddly absent.

The subsequent parts of the article examine the relationship between the professionalisation of Polish physicians and abortion law between 1918 and 1989. The article is divided into sections, corresponding to key periods in Polish history and

to key stages of medical professionalisation. The first period covered is the partition era (1772–1918), in which Polish territory was divided between the Russian, Prussian, and the Habsburg Empires. During that time Polish physicians experienced regionally distinct processes of professional institutionalisation. The second period covered is the Second Polish Republic (1918–1939), which was characterised by legal, political, and socio-economic reforms and saw the establishment of the Polish Chamber of Physicians in 1921. The third, post-war, period (1945–1989)—the Socialist period in Polish history—witnessed comprehensive policies of nationalisation and centralisation, the abolition of the Polish Chamber of Physicians in 1950, and the introduction of liberal abortion legislation in 1956. A separate section is devoted to the Solidarity movement in the 1980s. The first Solidarity strikes (1980) are identified as a formative moment in the history of the medical profession, which placed abortion law on a distinctive trajectory (Capoccia and Kelemen 2007, 342). The alliance between the medical profession and the new elites strengthened after 1989 during the period of democratisation and socio-economic transition led to the adoption of one of the most restrictive abortion laws in Europe. The article notes that the recent judgment of the Polish Constitutional Tribunal (K1/20) imposing further draconian restrictions on access to abortion may mark the end of this alliance (Krajewska 2020b). The article concludes by sketching the wider implications of its findings and proposing a research agenda for the future.

Explaining Legal Institutional Change Through the Prism of Professionalisation

The influence of partitions on the Polish medical profession and abortion laws

Sociologists of professions established long ago that professionalisation in continental Europe was largely determined by state planning (Sciulli 2009, 42). States fostered professions through specialised educational institutions, with practitioners organised in government-regulated corporations and chambers (Burrage et al. 1990; Balzer 1996, 6). In particular, Prussia and Austro-Hungary, which occupied Polish territory in the period 1772–1918, promoted processes of medicalisation by introducing public health measures and compulsory health insurance legislation in the 1880s (Więckowska 2004; Urbanek 2009). Although physicians viewed this legislation as limiting their autonomy, these policies gave them employment security and strengthened the links with the state (Huerkamp 1990, 77–78). The chambers of physicians introduced in Prussia in 1887 and in Austro-Hungary in 1892 formed a compromise between unrestrained competition and tight government regulation (Huerkamp 1990, 74–75; Cocks and Jarausch 1990, 14; Bukowska 2009, 172). In Tsarist Russia, which occupied the rest of Polish territory, the medical profession, originally associated with the army, evolved to resemble a civil service (Larson 1977, xviii). Consequently, the process of professionalisation was always Janus-faced. On one hand, the medical profession sought liberation from state control and professional self-governance. On the other, medical practitioners appealed for state

protection whenever their incomes and status were threatened by competition in the employment market (Kovacs 1994, 8–9; Balzer 1996, 11–13; Bailes 1996, 39–49).

It is difficult to speak of the *Polish* medical profession in any meaningful way during the partition period (1772–1918). Polish physicians practising in the Prussian, Russian, and Habsburg Empires constituted three separate groups, educated and practising in different legal, administrative, and healthcare systems (Nasierowski 1992; Jastrzębowski 1994; Więckowska 2004; Skrzypczak 2011). During that time a number of medical journals and societies, using the Polish language and expressing clear patriotic sentiments, appeared in the partitioned territories (Ostrowska 1989). Yet, the opportunities for cooperation between these groups were limited. In Prussia, Polish medical professionals constituted a small number of practising physicians, even in the Polish territories (Więckowska 2004, 18–19). Those medical professionals were also excluded from membership in professional and representative bodies, and they faced discriminatory ethnic and cultural policies directed against the Polish population (Więckowska 2004, 18–19). The position of Polish physicians on the Russian territory was even more difficult, especially after 1870, when the limited autonomy of the 'Kingdom of Poland' (i.e. the Polish Province of the Russian Empire) was abolished and policies of Russification were intensified. The powers of existing public health institutions were transferred to the Interior Ministry in St. Petersburg and medical education in the Polish province was suspended. Not Poles, but Russian civil servants occupied most regional medical offices (Więckowska 2004, 17). While Polish doctors could participate in scientific societies, such as the Medical Society founded in 1820, the chambers of physicians that existed under other partitioning powers were not established, and Polish doctors did not organise any scientific meetings equivalent to those organised by their Russian counterparts (e.g. Pirogov Society) (Nasierowski 1992; Więckowska 2004, 23). Polish medical professionals residing in Galicia, the former Polish territory colonised by the Habsburgs, enjoyed much greater organisational autonomy than their colleagues under Prussian and Russian control. Here, medical chambers could use Polish as their official language, and doctors were able to organise scientific societies, representing professional interests and providing them with social and financial assistance (Bukowska 2009). These organisations laid the ground for the organisational structures of the medical profession after Poland regained independence in 1918 (Skrzypczak 2011, 97).

Importantly, there is little evidence to suggest that Polish doctors opposed the laws and policies regulating access to abortion introduced in the three Empires during the nineteenth century. As in the Anglo-American context, the process of professionalisation coincided with the absolute prohibition and criminalisation of abortion, introduced in Prussia in 1851 (Kommers 1977; Eser 1986) and in the Habsburg Empire in 1852 (Kaniak 1969, 301). It is not a coincidence that, by the end of the nineteenth century, Prussian and Austro-Hungarian gynaecologists and obstetricians formed a professional group that strictly differentiated itself both from other physicians and from traditional healers dealing with women's reproductive health (Maehle and Pranghofer 2010). The first Societies for Gynaecology and Obstetrics were founded in 1885 in Prussia and in 1887 in Austria. In Tsarist Russia, abortion was initially placed in the same category of crimes as infanticide, except in cases of

medical necessity (Savage 1988). However, as a result of extensive reforms that took place in the period 1864–1903 (Timasheff 1953), punishment became gradually less severe. For instance, under the Penal Code 1885, a person helping a woman in the procurement or induction of abortion faced a sentence of up six years in prison and the loss of all private or professional rights or privileges, or a sentence of up to 10 years of hard labour in Siberia if the woman died or sustained serious injury (Savage 1988, 1035). The less punitive 'Tagancev' criminal code, partially introduced in 1903,[2] imposed a punishment of up to three years of imprisonment for trained professionals, who also—if convicted—lost their rights to practise medicine for up to 5 years (Mukhina 2012). The law was, thus, less severe than in areas under Prussian and Habsburg control. It could be argued that, in Russia, the absence of chambers of physicians tied to the state left space for more open discussions about controversial issues among physicians, lawyers, and policymakers. Progressive doctors and lawyers, connected to the 'Pirogov Society', led the debate concerning population growth and birth control, focusing on the relationship between abortion and social factors, living conditions, and women's rights. They opposed the pro-natalist policies that dominated in Europe at the time and initiated discussions about decriminalisation of abortion, as early as 1889, at the Society's 3rd Congress. Although expressly condemning abortion as a practice, participants called for a reduced punishment for women subjected to surgery, and for the recognition of legitimate medical abortions with regard to some illnesses (Severyanov and Anisimova 2013, 1069). These debates led to the adoption of a formal resolution calling for complete decriminalisation of abortion in 1913 (Avdeev et al. 1995, 40–41). The conceptualisation of abortion as a primarily social issue laid the basis for the—short-lived—legalisation of abortion in Bolshevik Russia in 1920 (Gross Solomon 1992). Importantly, doctors retained decision-making power over reproduction throughout the Communist period. There is little evidence to suggest that the developments in Russia influenced the attitude of Polish physicians or their professional organisations towards abortion after 1918. Separate criminal codes originating in the partition era remained in force in Poland until 1932. However, the arguments concerning population control and public health, developed in that time, resurfaced in debates concerning reproductive health that erupted in Poland during the interwar period. While they did pervade centres of political power, they had a clear influence on the legislative reforms concerning abortion in the 1930s (Boy-Żeleński 1930; Kuźma-Markowska 2009). This process could be seen as an early example of dialectical transformation.

[2] The 'Tagancev' Code (1903) was never fully introduced in Tsarist Russia. However, Germans who, in the summer of 1915, occupied a large portion of Western Russia, including former Polish territories, enacted it, in order to simplify the already very complicated legal situation. Due to its modern provisions, the 1903 Code remained in force after Poland obtained independence in 1918, and it was influential in the reforms aimed at consolidating the fragmented Polish criminal law system (Timasheff 1953; Koredczuk 2019).

The Medical Profession in the Second Polish Republic: State-Building Amidst Divisions

For all the destruction that it caused, World War I made possible the re-establishment of an independent Polish state. However, the Second Polish Republic (1918–1939) was fraught with difficulties. On the one hand, it saw many attempts at extensive social, political, and legal reforms. On the other hand, the rapid process of state-building resulted in obdurate political and socio-economic divisions, and the eventual consolidation of authoritarianism. It was also a turbulent time for the medical profession, which experienced (a) extensive legislative and institutional changes, stemming from the development of a state-led welfare system, (b) intensive processes of professionalisation and unification, and (c) a deep economic crisis (Bukowska 2009). From 1919 to 1921, the government established the foundations for a highly ambitious national social and health insurance system, based on compulsory sick funds (see Inglot 2008, 82).[3] While the system encouraged the development of private practice, most doctors—like many of their European counterparts—chose the relative security of employment provided by the state or insurance funds, increasingly controlled and supported by the state. At this time, it was the process of nation/state-building that reinforced the relationship of parts of the medical profession with the state.

Despite the state-building endeavours, the entire legal and institutional system in interwar Poland remained highly fragmented, and this was reflected at the level of healthcare provision. The Great Depression thwarted any real chance of overcoming divisions in the medical community induced by the partitions (Więckowska 2004, 156). Between 1929 and 1934, the government reduced spending on healthcare by 44–50%, whereas general public expenditure fell by 30%, obstructing the development of adequate infrastructure, hospitals, and outpatient clinics (Bukowska 2009, 176). Although the number of physicians increased by more than 100% between 1921 and 1939 (from 5500 to 13,000 doctors), in 1938 Poland was the state in Europe that had the fewest doctors per capita (one doctor per 2717 people) (see Indulski et al. 1978, 176). Rapid pauperisation exacerbated stark regional and socio-economic divisions between doctors employed in different sectors, in private practice and in sick funds, and in rural and urban areas. It also led to the rise of nationalist attitudes and the introduction of racial policies preventing Jewish students and doctors from entering the profession (Więckowska 2004, 204).

Importantly, 1921 saw the establishment of the first Polish Chamber of Physicians,[4] aimed at protecting the professional interests and representing physicians in their interactions with the public, the government, and the insurance funds (Kordel 2012). The creation of the Chamber was accompanied by evocative language of national, professional, and moral revival. Medical professionals have generally remembered the Chamber very favourably because of its contribution to the advancement and unification of the Polish medical education and professional

[3] Dz.U.1919.9.122; Dz.U.1920.44.272.

[4] Dz.U.1921.105.763; Dz.U.1934.31.275.

training. These achievements contributed to the myth of the 'liberal profession' in interwar Poland, forming the basis for the belief that at this time the medical profession exercised considerable medical autonomy, and they were often recalled as one of the main arguments in favour of the reinstatement of the Chambers in the 1980s (Skrzypczak 2011; Kordel 2012). However, recent historic accounts have revised this positive image. According to Więckowska (2004) and Bukowska (2009), the Polish Chamber of Physicians had very little impact either on the socio-economic position of medical professionals or on the healthcare policies of the Second Republic. Furthermore, the Ministry of Public Health retained extensive supervisory powers over their regulatory and judicial activities. This became manifest on many occasions, whenever Medical Courts imposed professional sanctions on physicians who disregarded their colleagues' opinions (Więckowska 2004, 238). At the same time, the Chamber did not counteract the divisions and tensions that existed among physicians, their trade unions, and scientific organisations. The outbreak of World War II found the medical profession internally divided along geographical, economic, racial, ethnic, and religious lines, relatively inactive, with representative bodies revealing organisational breakdown.

Paradoxically, these circumstances had formative significance in the development of abortion law, and they may help to explain why, by the mid-1930s, Poland possessed one of the most progressive abortion regimes in Europe. The Criminal Code 1932 replaced the three existing criminal law systems, which had regulated access to abortion since before 1918 and shaped the values of the medical professions for generations. The new provisions permitted abortion *without a time limit* in cases where (a) the life or the health of the mother was in danger or (b) the pregnancy was a result of an unlawful act (e.g. rape or incest).[5] The first ground warrants particular attention. Some legal scholars set out broad constructions of 'health', such that 'exhaustion' was, in some instances, interpreted as a sign of deterioration of health (Sobolewski and Laniewski 1932). As a result of the Code, a doctor could lawfully terminate a pregnancy if two other doctors confirmed the need for abortion on medical grounds.[6] As such, the new provisions of the Code offered a legal pathway through which liberal interpretations could develop, leading to wider access to abortion. In this respect, liberalisation of abortion law bears parallels with the processes in other jurisdictions, e.g. the UK (Thomson 2013).

This progressive regulation was adopted despite adverse social and political conditions. First, the legislative process, which began in 1920, was disrupted by persistent military conflicts and border disputes. Second, after the coup of 1926 Poland became a partly authoritarian state, marked by increasingly nationalist political rhetoric, expanding criminalisation of social practices, increasingly punitive laws (Lityński 2012, 210), and a powerful Catholic Church.[7] Third, the majority of Polish doctors did not support the liberalisation of the abortion laws inherited from the three Empires (Wachholz 1933). Gynaecologists in particular often spoke out

[5] Dz.U.R.P.1932.60.571.
[6] Dz.U.1932.81.712.
[7] Dz.U.1925.72.501.

against birth control and abortion in the public and specialist press (Wierzbicki 1932). This occurred despite the fact that they often discussed abortion in terms of 'necessary' or 'artificial' miscarriage, and they widely used contraceptive methods in their own private lives (Kacprzak 1933). Similar conditions prevented other European countries from adopting more liberal abortion laws until after World War II.

However, the challenges experienced by the Polish state created propitious circumstances for the liberalisation of abortion law, which came together in 1932. First, while the Catholic Church obtained a privileged position in the constitutional structure of the state, the multi-ethnic and multi-confessional composition of Polish society meant that the Church could not monopolise religious and moral discourse. Second, as mentioned above, most medical professionals, preoccupied with constant structural reforms of the healthcare system, were not actively involved in the heated debates about birth control that took place in the popular and specialist press (Kuźma-Markowska 2009, 167). In addition, while the official medical organisations, including the Polish Chamber of Physicians and the Warsaw Gynaecological Society, acknowledged the necessity for regulation of reproductive health, they distanced themselves from the issue of abortion by claiming that science and medical expertise were politically impartial (Boy-Żeleński 1930). Consequently, in the first decade of the Second Republic, the conservative faction of the medical profession—holding decision-making power—saw no need to mobilise around abortion, which remained at the periphery of the political agenda.

The discursive space left vacant by formal medical organisations was filled by a small yet vocal group of feminist writers and progressive doctors, who actively campaigned for the improvement of women's reproductive health and rights in the 1920s and 1930s (Kuźma-Markowska 2009). Such actors drew attention to the appalling socio-economic situation of Polish women; as approximately 70% of the population fell outside the insurance system, the majority of women were denied access to healthcare (Sokolowska and Moskalewicz 1987, 764). Influenced by Malthusian theories—as reformulated by Marie Stopes in the West and the Pirogov Society in the East—these activists argued that Poland was threatened by overpopulation, and they underlined the negative consequences of the criminalisation of abortion, and the high mortality rates resulting from unlawful terminations (Gawin 2000, 220–21). In 1932, they founded the Society for the Promotion of Conscious Motherhood and Customs Reform, with clinics offering free healthcare and advice. The Society was unpopular among physicians, who thought that it undermined their economic position, and often refused to refer women to its clinics (Boy-Żeleński 1936; Kużma-Markowska 2009).

This small group of liberal doctors found allies in the legal establishment, especially amongst prominent lawyers, who were members of the Codification Committee, which drafted the Criminal Code 1932. Alliances of this type were very unusual, but they were made possible by the background of the Codification Committee, which was created in an unprecedented cross-party move in 1919, and was originally conceived as an interim advisory body. As such, the Committee was able to incorporate liberal members of the legal establishment. Several of its members, including the former presidents of the Supreme Court and the Court of Appeal, who drafted the relevant abortion provisions, were in favour of complete decriminalisation of

abortion (Boy-Żeleński 1932). Their initial proposal to decriminalise abortion on socio-economic grounds was eventually rejected by the government during a consultation process that had taken place behind closed doors before the new law was introduced by a presidential order (Lityński 2012). However, the Code of 1932 remained in force for decades. Its abortion provisions were amended with the introduction of the Abortion Provision Act 1956, long after the transition to Socialism. Similarly, the legacy of the Conscious Motherhood Society continued after World War II, when it was reactivated in 1957.

Prima facie, the development of abortion law in the Second Polish Republic cannot be easily aligned to the trajectories characterising countries in Western Europe and North America, where the medical profession skilfully utilised abortion debates to strengthen their already powerful socio-economic position. On the one hand, the medical profession—despite its expansion and professionalisation—remained weakly institutionalised and deeply fragmented. As explained above, it was the legal rather than the medical establishment that influenced the development of abortion law. However, one should not forget that the highly praised legal reforms—while progressive in comparative terms—placed abortion firmly in the hands of the medical profession. These reforms supported the medicalisation of abortion and strengthened the position of physicians vis-à-vis other healthcare professionals and traditional healers (Malarewicz and Sola 2011). Even those physicians who criticised the Criminal Code as too restrictive supported the provisions that imposed grave sanctions against midwives (Landau 1933). Consequently, medical professionals widened the scope of their corporate and clinical autonomy, securing the protection of law enforcement institutions in the struggle with their competitors and solidifying their privileged position in society, as part of the intelligentsia.

The next section demonstrates how certain elements of this legal, professional, and institutional framework remained in place despite regime change after World War II. It analyses the factors that allowed groups, which positioned themselves in opposition to mainstream medical organisations in the Second Republic, to assume the role of influential actors, shaping reproductive policies under Socialism.

The Medical Profession and Abortion Under State Socialism

World War II is among the most important caesuras in Polish history. The level of destruction caused by the war is difficult to comprehend. Poland lost over 20% of its population and 38% of its national capital (Czubiński 1992). This devastation was disproportionately reflected amongst medical professionals. Over 45% of Polish physicians lost their lives, and approximately 55% of the medical infrastructure, including 75% of existing hospitals, was partially or completely destroyed (National Statistical Office 2015, 40; Grata 2017, 7). At the same time, Poland came under Soviet influence and embarked on a Socialist ideological project. Naturally, this had enormous consequences for the Polish state, society, and for the development of the medical profession. The period of the Polish People's Republic (1945–1989) was marked by unprecedented expansion of the medical profession, the nationalisation of the healthcare system, and the liberalisation of abortion law in 1956. It is argued

here that, despite losing corporate autonomy, the medical profession managed to strengthen its socio-economic position during this time. While initially gynaecologists opposed the decriminalisation of abortion, it did in fact strengthen their monopoly on the reproductive services market. Furthermore, it is argued here that it was the general healthcare reforms in the late 1940s and early 1950s (Sadowska 2002; Prętki 2007) that paved the way for the liberalisation of abortion law and the next step in the dialectical transformation of the medical profession, and these could be seen as a formative moment shaping reproductive rights for decades.

The new Socialist healthcare system was introduced in the late 1940s. Based on the Soviet 'Siemaszko' model, it was highly centralised, universal, free, comprehensive, and—at least in principle—easily accessible (Prętki 2007; Paszkowska 2017). In 1948, the government adopted the *Act on Social Health Care Institutions and Planned Economy in Health Care*, which nationalised all healthcare facilities previously run by municipalities, insurance funds, charities, churches, and religious associations.[8] This Act established a state monopoly on the creation and management of all healthcare services and it introduced a planned economy in the sector. It also transformed all healthcare professionals into state employees, and imposed an obligation to work in public healthcare facilities for a certain period of time and introduced strict employment regulations. While private practice was discouraged and criticised for exacerbating social inequalities (Nasierowski 1992, 138–139; Sadowska 2002, 63), it was never entirely prohibited and in fact existed throughout the Socialist period (Millard 1995, 180; Sokołowska and Moskalewicz 1987). The Act introduced universal healthcare and uniform centralised state management, abolishing all other healthcare funding (Indulski et al. 1978, 284). Together with the *Act on the Medical Profession* (1950)[9] and the *Act on the State Administration of Healthcare* (1951),[10] it created the legal basis for the Socialist healthcare system (Pacho 1972, 20). This process was finalised with the adoption of the new *Constitution of the Polish People's Republic* (1952), which introduced the universal right to health protection and assistance in the event of illness or inability to work (Art. 60).[11] Critics pointed out that the newly created system was excessively bureaucratic and strongly politicised, privileging the industrial working class (Sokolowska and Moskalewicz 1987, 765). However, most Poles, exhausted by war, supported the changes that promised the creation of a healthcare system that was more equal and just than that established in the Second Polish Republic (Kennedy 1991, 23). The new model was favoured by many physicians who understood their work as a public service rather than a free profession (Sokolowska and Moskalewicz 1987, 764).

For the medical profession, Socialism involved in many ways a reinforcement of the already existing tendency towards "professionalisation from above" (Siegrist 1990, 46). The state assumed responsibilities for education, licensing, management, and adjudication of professional and legal liability. The post-war years saw

[8] Dz.U.1948.55.434.
[9] Dz.U.1950.50.458.
[10] Dz.U.1951.67.466.
[11] Dz.U.1952.33.232.

the opening of all healthcare professions and the rapid development of state-directed medical education and professional training. Consequently, from 1950 to 1965, the number of doctors increased from 9200 to 39,613 (Lipińska 2009), reaching 79,247 doctors in 1989 (Statistical Yearbook 1990, 493). At the same time, healthcare professionals lost their corporate autonomy and formal political representation in 1950, when the chambers of physicians, dentists, and pharmacists—briefly reinstated after the war[12]—were abolished.[13] Many functions formerly performed by the chambers were absorbed by the Ministry of Health, state-controlled trade unions, and scientific associations.[14] For instance, in 1967, the Polish Association of Physicians adopted the Ethical and Deontological Principles, which were subsequently integrated into the formal professional liability proceeding conducted by the Ministry of Health and Social Care (Kielanowski 1980). Consequently, it was the government, i.e. the state party, rather than the profession itself, that gained formal means of control over physicians' behaviour. This in turn helped reduce the oppositional attitudes of many gynaecologists who spoke against the liberalisation of abortion law and presented abortion procedure as dangerous and traumatic (Ignaciuk 2021). In line with the logic of dialectical transformations, those physicians who belonged to the political mainstream during the Second Polish Republic were often marginalised.

In addition to losing their power to self-regulate, it is claimed that healthcare professionals lost their clinical autonomy in everyday medical practice (Millard 1995). The destruction caused by World War II and the ineffective centrally planned economy led to many shortages of medicines and equipment and prevented the adequate development of the healthcare infrastructure (Hoffman 1997, 352). The living and working conditions of the medical professionals were difficult, especially in rural areas (Lipińska 2009). The disparities between the number of doctors in urban centres and in the countryside were particularly shocking. In 1955, the number of gynaecologists in the country was 827, out of which fewer than 7% worked in rural areas (National Statistical Office 1956, 368–369). Important appointments in healthcare institutions (e.g. hospital directors) required political approval. This led to the development of a 'feudal', i.e. highly hierarchical and clientelist, system of healthcare (Kubot 2007, 21–22). Finally, it is commonly accepted that clinical autonomy was further constrained by laicisation policies. These policies included (a) the abolition of the freedom of conscience clause foreseen by the Principles of Medical Deontology 1935[15]; (b) the removal of religious symbols from healthcare facilities; and (c) the removal of clergy from managerial and administrative positions in hospitals and medical schools (Jarkiewicz 2017). Consequently, it is argued that the majority of the Polish medical professionals withdrew from political life (Persa and Krawczyk 2009).

[12] Dz.U.1946.64.354.
[13] Dz.U.1950.36.326.
[14] Dz.U.1950.36.332.
[15] Dz.U. Izb Lek. R. 6.8.1935.

At first glance, the liberalisation of abortion law in Poland in 1956 could be seen as part of this wider trend towards centralisation and state control. The *Act on the Conditions of Lawful Pregnancy Termination* (1956) (hereafter, Abortion Act 1956),[16] which decriminalised abortion for women and introduced socio-economic factors as a ground for lawful termination of pregnancy, was a legal transplant of the liberal laws introduced in the USSR in 1955. It has been argued, accordingly, that the law was imposed on the Polish medical profession, which had by that point lost all meaningful mechanisms of political and legal contestation. The fact that in the early post-war years the medical profession pushed for further restrictions of the reinstated Criminal Code 1932 and broader medical controls over female reproduction supports such interpretation (Jarkiewicz 2017). Such claims are also corroborated by reports of the dismissal of gynaecologists who—for different reasons—refused to perform abortions on socio-economic grounds subsequent to the adoption of the Abortion Act 1956 (Fidelis 2010, 198–200; Jarkiewicz 2017, 406–407).

Nonetheless, the claim that the medical profession lost all their professional autonomy and unilaterally opposed the liberalisation of abortion law is far from the truth. The Abortion Act 1956 was a consequence of much wider and more complex processes in society (Titkow 1999; Fidelis 2010; Grabowska 2018; Kuźma-Markowska 2019). First of all, the rapidly growing birth rates in Poland in the decades after 1945, coupled with the enforced labour participation agendas, led to a shift away from the pro-natalist policies of the immediate post-war period and to the liberalisation of abortion law. The dominant rhetoric preceding the Abortion Act 1956 focused on the protection of women from unnecessary deaths resulting from the widespread unlawful abortions that were being conducted despite their criminalisation (Klich-Kluczewska 2012a, b). Second, these campaigns coincided with the period of de-Stalinisation and liberalisation in Polish politics, which culminated in the riots of October 1956. The progressive faction of the medical profession and women activists clashed with Catholic and Conservative deputies and gynaecologists in the Polish Sejm and won the battle in the same month (Czajkowska 2012, 151). Polish pre- and post-war birth controllers, who in 1957 revived the Society for Conscious Motherhood, constituted an important voice in the debates about Polish reproductive politics (Kuźma-Markowska 2019). Consequently, there was a clear discursive continuity between the arguments used in the parliamentary debates and those of the interwar period concerning population control and the health and safety of working women and their emancipation. This time, however, the interests of the physicians ostracised before World War II became aligned, however briefly, with those of the Socialist government, providing further evidence of the process of dialectical transformation.

Crucially, the Abortion Act 1956 provided doctors with almost exclusive decision-making powers, far exceeding their medical expertise. Gynaecologists in regional medical offices were given the power to assess whether women met the threshold of 'difficult living conditions' that entitled them to a lawful abortion. Between 1956 and 1959, women seeking abortion were required to submit detailed

[16] Dz.U.1956.12.61.

documentation regarding their existing children, family income, living conditions, and their husband's health. Where there were serious doubts, the doctor or nurse was obliged to seek further information from social services or to pay home visits to check the woman's credibility.[17] In 1959, the Ministry of Health issued special regulations according to which women were only required to provide a statement about their difficult socio-economic situation, which the doctor had to file, but could not scrutinise.[18] This removed some of the responsibility from the medical profession, but upheld their overall position. While doctors could no longer act as gatekeepers to abortion services, most of which were now performed on socio-economic grounds, they preserved a monopoly on such services. It is important to remember that abortion performed outside the scope of the Abortion Act 1956 remained a criminal offence, punishable by a maximum sentence of three years in prison.[19] Free abortion was only obtainable in a public hospital, under professional supervision.[20] Furthermore, the subsequent development of ultrasonography led to the re-engagement of medical professionals in the decision-making process concerning abortions on the grounds of foetal abnormality (Ignaciuk 2021, 20). Gynaecologists, who—owing to high demand for their services—could easily establish private practices, enjoyed a much higher degree of organisational and financial independence than other healthcare professionals.

Consequently, the 1960s and the 1970s saw a normalisation and rising acceptability of abortion provided by qualified physicians. In 1965, there were over 168,000 registered abortions. This number remained high up to 1988, though falling to 105,333 reported abortions that year (Government Report 1999). The phenomenon of unrecorded abortions remained and was variously estimated at 55,000–85,000 abortions annually (Fuszara 1991; Kulczycki 1995). However, as a result of the Abortion Act 1956, the abortion-related mortality rate fell dramatically from 255 cases per annum after 1956 to only twelve in 1973 (Fuszara 1991, 119). Furthermore, studies conducted in the 1960s showed that more than 70% of respondents considered that it was wrong for a physician to refuse to perform an abortion. While always uneasy about the religious implications of abortion, most Poles came to perceive it as a moral and legal right (Kurczewski 1972).

To summarise, by entering into a renewed alliance with the state, healthcare professionals retained control over abortion throughout the Socialist period. The often-lamented loss of regulatory autonomy at the turn of the 1940s/1950s not only constituted a formative moment in the development of reproductive rights; in addition, it presented no challenge to professional control. According to Fidelis, decision-making power with regard to all the medical aspects of abortion allowed the medical profession both to reinforce traditional gender roles, in which women were understood first and foremost as mothers, and to police women, making sure those who were considered "fit" gave birth (Fidelis 2010, 198). As such, the medical

[17] Dz.U.1956.13.68.

[18] Dz.U.1960.2.15.

[19] Dz.U.1969.13.94.

[20] This kind of regulatory solution could be seen as the precursor of the current trend to decriminalise abortion in countries such as Australia (Baird 2017; Millar 2017).

profession pursued the ideological aims of the state related to population control, social engineering, and its renewed trust in objective science and medicine. In presenting abortion as an intricate medical procedure, whose success depended on the skills of highly qualified and experienced physicians, Socialist doctors perpetuated and strengthened the medicalisation of abortion, depicting it as an illness serious enough to require professional care (Kuźma-Markowska 2017). By further undermining the expertise of other healthcare professionals, gynaecologists cemented their privileged role as the most important decision-makers in the field of reproduction. Finally, while the pre-1939 intelligentsia—directly attacked by the Socialist state—had suffered a loss of prestige, physicians managed to retain their status. In the 1960s, approximately 70% of the population expressed the view that the medical profession was as or more prestigious than had been the case before the war, and physicians were still seen as the second most esteemed profession in society, after university professors (Sarapata 1971, 149, 160). The social authority of physicians was incomparable with that of other healthcare professions (e.g. midwives, nurses, lab technicians), as they continued to be seen as part of the elite Polish intelligentsia (Domański and Sawinski 2010, 85). Nevertheless, the medical profession was no longer the same. Perhaps paradoxically, the Socialist period, especially in its initial stages, laid the foundation for the mass involvement of the medical profession in the Solidarity strikes in the 1980s that heralded the end of Socialism and a new era in abortion politics.

The next section demonstrates how physicians retained their privileged position and control over reproduction through the collapse of the system of State Socialism. It identifies the period around the first Solidarity strikes in 1980 as a critical juncture, in which physicians aligned themselves to the newly forming elites and began to conform to the new state ideology that was consolidated after 1989. The relevance of period for the dialectical transformation of the medical profession and abortion law warrants discussion in a separate section, as a distinct époque in post-1945 history.

The Solidarity Period as a Critical Juncture in the Dialectical Transformation of the Medical Profession and Abortion Law

The Solidarity movement in the 1980s is invariably seen as an important formative moment in Polish post-war history. It has been described as a broad anti-bureaucratic social movement that used the methods of civil resistance to advance the causes of workers' rights and social change, which contributed to the fall of State Socialism in Poland (Smolar 2009). The complex political and socio-economic factors underlying the emergence of the Solidarity movement have been subject to extensive analysis (Staniszkis 1984; Ekiert 1996; Ost 2005; Inglot 2008). Such research converges around the claim that Solidarity emerged because of a unique combination of structural factors, including the macroeconomic crisis in the 1970s, a brief alliance between the working class and intelligentsia, centralised yet ineffective authorities, "and a set of 'innovations' such as occupational strikes" (Kennedy 1991, 56). Several scholars have investigated the impact of the Solidarity movement on elite

formation in post-Socialist society (Szelenyi et al. 1995; Zarycki 2008). However, only Kennedy has examined in detailed the ways in which the medical profession was involved in the Solidarity movement. In this regard, it is noted with puzzlement that the medical profession, which depended on the continued support of the state for power of broader scope (Kennedy 1991, 290), and which was traditionally unlikely to go on strike, could join a movement that described itself as "anti-state", "anti-parties", and "anti-politics" (Ost 2005, 4). It is also noted with surprise that members of this profession retained their privileged position in the aftermath of the strikes and eventually preserved organisational autonomy in the late 1980s. As will be demonstrated below, it is during the Solidarity period that the alliance between the medical profession and the new elites was formed, which determined the fate of the abortion law in Poland after 1989.

On one calculation, the participation of physicians in the Solidarity movement was at times as high as 80–90%, and 20% of healthcare professionals took active part in the strikes (Kennedy 1991, 290). To explain their large-scale participation, medical professionals referred to the crisis in the healthcare system at the end of the 1970s. While between 1960 and the 1970s Poland experienced a period of socio-economic stability linked to foreign loans, the consequences of the economic crisis and political unrest at the end of the 1970s were particularly acute in the healthcare sector. National healthcare spending fell from 4.3% in 1970 to 3.7% in 1978, placing Poland among Socialist countries with the lowest level of health expenditure as a fraction of GDP (Sokołowska and Moskalewicz 1987, 769). The economic crises and mismanagement of health resources led to poor healthcare infrastructure and shortages in medicines and medical equipment, which gave rise to health and safety risks and the lowering of professional standards. Two critical reports prepared by the think tank 'Experience and Future' (DiP) in 1979 and in 1983 drew attention to the overcrowding of old dilapidated hospitals, the severe shortages of beds, and the lack of basic infrastructure such as lifts, heating, or air conditioning. While in 1977, 280 drugs were in short supply and 68 were completely unavailable, by 1982 there were problems with the availability of up to 600 drugs (DiP 1979, 1983). Additionally, resources and manpower were unevenly distributed between urban centres and the countryside, and political elites clearly had facilitated access to them (Sokołowska and Moskalewicz 1987, 768–772). This had a considerable impact on clinical autonomy and the decision-making power of doctors, who by that time enjoyed a high social status and authority. Moreover, despite some attempts at reforms, the official wages for Polish physicians remained low from 1945 up to the 1980s period, especially in comparison with employees in nationalised industries (National Statistical Office 1981, 190–191). This led to considerable frustration, tensions between the medical profession and the state, and calls for a return to professional self-regulation. By the late 1970s, 'physicians recognised that an alliance with the self-organised working class was necessary to minimise their dependence on the authorities' (Kennedy 1991, 307).

As mentioned earlier, an alliance of this kind was not easy to construct, for parts of the medical profession (e.g. consultants, heads of units, hospital directors) held a very privileged position in society. The difficult financial circumstances of many physicians were usually mitigated by the fact that they held several posts at once. In

1977, over 60% of doctors held at least two appointments. The ability to hold more than one job meant that they had more responsibility, but it also meant that they earned more than other healthcare professionals (Kennedy 1991, 303). Despite this, a set of circumstances that coincided in 1980 created a conjuncture in which higher-ranked doctors became likely to join Solidarity. By the late 1970s, the Polish intelligentsia had forged an alliance with the working class. This brief "love affair" (Ost 2005, 40) between intellectuals and the working class helped medical professionals to paper over the antagonisms between the severely underpaid healthcare workers—nurses, midwives, and lab technicians—and the medical establishment. In addition, the transformation of the healthcare system, the unprecedented expansion of the profession, and the difficult working conditions under Socialism meant that it was easy for the medical profession to incorporate improvements in healthcare provision in the list of demands presented by Solidarity to the government in August 1980.

This emphasis on the quality of healthcare for the country allowed all healthcare professionals to connect the Solidarity strike with their own salary demands. Healthcare professionals ensured that demands for their regulatory autonomy and for increased salaries, including for more highly ranked physicians, were integrated in the list of necessary improvements in healthcare infrastructure requested by Solidarity. These demands were presented as necessary means to achieving improvements in the health of the workers and the population. The extensive participation of senior physicians in the Solidarity movement was far more likely to have been prompted by concerns for professional interests than by anxiety about the health of the Polish population (Kennedy 1991, 327). This is also the reason why specialist doctors, e.g. gynaecologists, who had more opportunities to earn high private-sector profits, were less likely to play an active role in the Solidarity movement.

One outcome of the strikes was that physicians used them as an opportunity to promote renewed professional self-regulation, which became an integral part of the flagship project of the Solidarity movement, focused on self-governance (Kordel 2012). After 1986, the Sejm considered eleven legislative proposals regarding professional self-regulation, which eventually led to the re-establishment of the Polish Chambers of Physicians in 1989.[21] The establishment of the Chambers is usually seen as one of the great achievements of the democratisation process after 1989. Yet, its foundations are linked to the period of the first Solidarity, in 1980–1981. In fact, physicians active in the heath section of the Solidarity movement completely dominated the authorities of the newly created Chambers of Physicians in 1989. The Chambers were given unprecedented powers of self-regulation, which included licencing, jurisdiction over professional liability, and the right to set professional standards. Importantly, the Chambers are independent bodies, which are subject only to law.[22] This had grave consequences for the development of abortion law in Poland after 1989.

The reason why the Solidarity strike 1980 can be seen as a critical juncture in the development of abortion law is that it led to a broader alliance between the

[21] 38th Session of the Polish Parliament (1985–1989), 17.05.1989 (38/16–47).

[22] Dz.U.1989.30.158.

medical profession and the Catholic Church. It was during that brief moment that the alliance between the Solidarity movement and the Catholic Church was finally reinforced. Consequently, Catholic healthcare professionals became key actors in Solidarity's leadership and institutional structures. They immediately took it upon themselves to revive the campaigns against abortion law initiated by the Church and Catholic organisations in the late 1950s (Persa and Krawczyk 2009; Jarkiewicz 2017). Despite the suppression of Solidarity in the 1980s, these campaigns eventually resulted in a legislative proposal endorsed by the Polish Episcopate in 1989, which aimed to prohibit abortion entirely (Fuszara 1991, 122). It is, therefore, no coincidence that it was the Catholic doctors, prominent in the Solidarity movement, who obtained high positions of authority in the newly re-established Chambers of Physicians and found themselves at the centre of professional power after 1989.

The Role of Medical Organisations in the Development of Abortion Law After 1989

During the first General Assembly, the Polish Chamber of Physicians adopted a resolution calling on the Polish Parliament to revise the Abortion Act 1956. It committed the Chamber to 'actively participate in the preparation of the new bill on the protection of the conceived life'.[23] The second Extraordinary General Assembly adopted the first Medical Code of Ethics in 1991.[24] At least three of the five members of the Working Group, entrusted with the drafting of the Code, were closely connected to Solidarity and the Church. Consequently, the Code that they proposed contained a provision that allowed doctors to 'risk the life of the foetus only in cases where it was necessary to save the life and health of the mother and in cases where the pregnancy resulted from a criminal act' and that prohibited abortion if the foetus was diagnosed with a developmental or genetic disorder (Art. 37). These provisions were in clear contravention of the Abortion Act 1956, which was in force at the time. The newly appointed Polish Ombudsperson challenged the relevant provisions of the Code and the Chambers' law-making powers in a series of cases brought before the Constitutional Tribunal in 1990 and 1992.[25] However, the Chambers—by now strongly aligned to the interests of the new governing elites and the Catholic Church—continued to pursue a strong pro-natalist agenda and to lobby in favour of the re-criminalisation of abortion. They fiercely supported the adoption of the current *Act on Family Planning, the Protection of the Human Foetus, and Conditions Permitting Pregnancy Termination* in 1993.[26] They also remained open to direct

[23] Lekarz.1989.12.11.
[24] Lekarz.1991.12.14.
[25] TK U 8/90, OTK 1991.8; TK U 1/92 OTK 1992.38; W 16/92, OTK 1993/I poz. 16, 156.
[26] Dz.U.1993.17.78.

pressures from the Catholic Church, which after 1989 was allowed to influence and obstruct the professional and/or political careers of doctors with liberal leanings who argued against such changes. In some instances, such pressures even included refusals to conduct Catholic funerals for such doctors (Kozerawska 1997).

While some members of the medical profession argued strongly against such changes, most of them remained silent and disengaged (STER 2018). Once again, the medical profession aligned itself to the state and its new ideology. This time, the alliance had disastrous consequences for Polish women, which persist to this day. The role of the medical profession in the restrictive interpretation of abortion law and its violation in medical practice in Poland is well known and widely reported.[27] None of the medical organisations opposed the ruling of the Constitutional Tribunal, which struck down a provision permitting abortions on socio-economic grounds, briefly introduced by the Social Democratic government in 1996.[28] On the contrary, the conservative legal activism of the Polish Chamber of Physicians has been well illustrated by the number of cases before the Constitutional Tribunal, the last of which successfully widened the scope of the conscientious objection and limited access to abortion services.[29] There is no evidence to suggest that an explicit bargain was entered into between the medical profession and the newly formed political elite or that the new abortion legislation was part of a bargain, leading to the re-establishment of professional corporate autonomy. However, one cannot but wonder whether an underlying understanding to that effect has existed since the early 1980s, which has placed Polish abortion law on path dependence from which it will be very difficult to return.

It is only after the recent judgment of the Constitutional Tribunal (K1/20) that the Polish Chamber of Physicians (2020), the Polish Society of Gynaecologists and Obstetricians (2020), and the Polish Society of Human Genetics (2020)—in an unprecedented move—expressed 'deep concern' in relation to the restrictions resulting from the judgment. Such mobilisation could be prompted by fear of unacceptable restrictions on professional autonomy and an attempt to guard professional interests. Nevertheless, the public protests that erupted after the judgment, openly supported by a large number of physicians, could herald a rupture in the long-lasting ideological alliance between the medical profession and government authorities. This paper has demonstrated the potential significance of such mobilisation and the challenges that it could face.

Conclusions

Using the process of medical professionalisation as a prism, this article has examined the historical-institutional factors that have determined current Polish abortion law.

[27] European Court of Human Rights, *Tysiąc v. Poland* [2007], Application No. 5410/03, ECHR 2007-IV; European Court of Human Rights, *R.R. v Poland* [2011] Application No. 27617/04, [2011] ECHR 828,

[28] Dz.U. 1996.139.646; TK K 26/96, OTK 1997/2/19.

[29] TK K 12/14, OTK ZU 9A/15.143.

First, combining insights from social and historical studies of abortion, the sociology of professions, and historical institutionalism, this study has demonstrated that the behaviour of the medical profession is a logical consequence of historical patterns of professionalisation. While today the medical profession enjoys a special constitutional status as a 'profession of public trust'[30] and unprecedented corporate autonomy, the persisting rhetoric of a 'liberal, free profession' is a myth. The study has shown that the Polish medical profession is historically inextricably linked with state structures, and these links have made physicians and their organisations vulnerable to ideological changes in the structure of government. This vulnerability frequently meant that the medical establishment was able to change views with regard to abortion during systemic transitions. The internal fragmentation of the medical professional prevented it from becoming an influential decision-making power in the history of the Polish state, until the 1980s. The only time in which physicians appeared united was during the first Solidarity movement in 1980. Due to a specific set of circumstances, this brief period of contestation became a critical juncture, at which the idea of self-governance returned as a real political possibility, which eventually materialised in the late 1980s. It was also at this point that the conservative groups in the medical profession, backed by the increasingly powerful Catholic Church, became the decisive voice in the Solidarity movement and managed to dominate abortion debates in the next decade. This was to have profound consequences for the development of abortion law in Poland after 1989, when oppositional physicians gained power in professional regulatory bodies. This critical juncture—when considered together with the traditional dependence on the state—explains the position and conservatism of the Polish Chamber of Physicians and its stance towards abortion.

Second, while throughout its history the medical profession remained heavily dependent on the state, it would be a fallacy to see it as weak and powerless. Over the last hundred years, it has been highly successful in retaining its privileged position and social authority. Like their Western counterparts, Polish physicians have utilised abortion law to achieve that goal at every opportunity at different points in history. In particular, this article shows that, despite different developmental trajectories, medical regulatory bodies in different geopolitical contexts traditionally tended to be opportunistic and conservative, and to have little regard for women's rights. The medical profession continues to use this understanding of scientific knowledge to retain its societal authority.

Last but not least, this article has argued that the development of the legal and institutional framework of abortion care constitutes a perfect example of 'dialectical transformations'. That is, it allows us to see how, in some contexts, certain institutions and actors, operating on the peripheries of one institutional system, become dominant players in a different system, as a result of particular critical junctures and systemic change. Institutions displaced in one system may submerge to a level of latency, but the values and structures on which they are based are never completely lost. Such institutions often reappear in modified form after prolonged periods of

[30] Dz.U.1997.78.483.

suspension. At the same time, the analysis has demonstrated that historical moments of exogenous shock do not necessarily overlap with, and they cannot always be cited as the sole causes of, legislative and institutional change. Legal frameworks consist of a patchwork of new and old rules and principles, which evolve and influence each other over time. Most importantly, discussion of the continuous relationship between the medical profession and the state has indicated that there exist residual structures that influence collective professional actions, and which penetrate so deeply that they can influence individual behaviour and attitudes.

This analysis has quite profound practical consequences. The long-term historical perspective presented here provides a description of a profession that is deeply divided and evades straightforward or binary conceptualisations. Women's rights activists may observe this as a framework in which it is possible to reactivate structural resources amongst medical professionals, which still remain influenced by the legacy of social medicine, which became prominent in the Second Republic and after 1945. Building pockets of resistance by calling on such resources is particularly important today, when abortion law seems to be in flux and we may be witnessing a crucial, or even formative, moment of contingency in Polish society. Women's rights activism needs to be supported by more research examining the relationship between (a) medical and legal expertise and epistemologies; (b) the legal consciousness of the medical profession; and (c) the impact of the legal profession on medical practice and on the development of abortion law. The research should not be limited to Poland, but should include individual and comparative studies of the medical professions in other (long) transitional and post-imperial contexts. Only such a multifaceted response can offer hope for the improvement of women's reproductive rights in Poland and in other transitional societies with restrictive abortion regimes across the world.

Acknowledgments I would like to thank the anonymous reviewers for *Feminist Legal Studies* for their valuable comments on my original submission. I would also like to thank all participants of the IGI. Workshop on the Impact of the Medical Profession on Abortion Laws in Transitional Societies, which took place at the University of Birmingham, UK, 4-5 April 2019. Special thanks are due to Chris Thornhill for the discussions that helped clarify the argument presented in this article.

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