THE MONASTIC CONTRIBUTION TO MEDIAEVAL MEDICAL CARE

Aspects of an earlier welfare state

D. A. FURNISS, M.R.C.S , L.R.C.P., M.R.C.G.P.
Leeds

IN ENGLAND in the Middle Ages the number of monasteries rose to about one thousand. The total population of the country was between two and three millions. Thus, in addition to the normal places of worship, there was one monastery to every 2–3,000 people. It is truly amazing that the population could support this lavish scale of provision. Eventually the burden proved too much, but that is the story of the reformation.

These monastic establishments were inhabited by monks, canons or friars or their female equivalents. The community was styled abbey, priory or friary according to the organization adopted by the inhabitants. An average establishment might contain about 20 but the number of inhabitants varied from single figures to several hundreds. Most religious houses employed a number of lay retainers. One of the largest English monasteries was the Cistercian Abbey of Rievaulx in Yorkshire where dwelt 200 monks and 400 lay brethren. Nearly every monastery had its sick bay. Some had more than one to cater for different sections of the community. Hope and Bilson (1907) instances the largest Cistercian monasteries as having two infirmaries, one for the monks and one for the lay brethren. In addition to this there were 500 purpose-built hospitals in mediaeval England. A list of these together with the evidence for their existence and use is given by Knowles and Hadcock (1953). These were staffed by monks, canons or nuns of whom there would usually be between ten and twenty.

The function of hospitals and monasteries was roughly the same. Illness was regarded by most people as a form of divine punishment. The monasteries were founded on private initiative to intercede for the souls of the living and the dead. The hospitals were founded similarly, but here the emphasis was on the practical relief of suffering: in the monastery more attention was paid to spiritual care; the difference was in degree.

J. ROY. COLL. GEN. PRACTIT., 1968, **15**, 244

The daily routine in both kinds of establishment was a similar blend of prayer and ritual. Artificial lighting was expensive and not very effective. Consequently the day was divided, not by the hours of the clock, but by accepted periods which could be shifted according to the season of the year and the daylight to be expected. Words like 'matins' and 'vespers' spring from this usage. The monastic habit of early rising may have left its imprint on hospitals in Britain. This very morning patients all over the country, without any particular regard to the condition for which they are in hospital, will be wakened at six, and given tea. They are then free to occupy the remaining two hours before breakfast with further sleep or ablutions.

On the theory of causation of illness which was generally held in the Middle Ages, treatment was superfluous: prevention and cure were fully provided by the activities of the church in general. It was understood that the cure might not be achieved in this world, but an important part of the service the Church provided was directed to 'follow up' in the next world. Facilities were comprehensive in the light of then existing knowledge. On the spiritual side, prayers could be bought (Williamson 1957). Plans as complex as any life insurance agent could now produce were evolved to cover all anticipated needs. The examples quoted below are for fatal illness but the pattern was the same for less fatal situations.

A popular plan appears to have been a Soul Mass on the first, third, seventh and thirteenth days after death, with an Obit or anniversary Mass, each year for ten years. Almost as popular was the Trental which was a daily Mass for 30 days. As now prices varied. During one period Obits were quoted at 2s. 6d. at Waltham Abbey out in the country, but old St Pauls, being fashionable and in town, charged £2 (Cook 1947). The wealthy sick, physically or spiritually, could found a chapel or endow a whole new monastery or hospital in the hope of ease. The more cautious might vow to found a monastery or hospital upon recovery. St Bartholomew's Priory and Hospital owed its foundation at Smithfield in 1123 to the vow of a royal jester. The vow was made under the duress of malaria which he contracted whilst on a pilgrimage to Rome (Cook 1961). To cope with the rising demands for prayers, extra altars were needed. Just as departments and units are to be found in all sorts of architecturally curious places in hospitals today, so altars were added to churches, to an extent never dreamt of by the original architects. A large abbey might have 20 or 30 altars in simultaneous use. In the later Middle Ages some abbeys found that the whole of the forenoon was taken up by continuous strings of Soul Masses and prayers for the alleviation of suffering (Cook 1947).

For many conditions neither prayers nor institutional care offered a solution. England suffered waves of bubonic and pneumonic

plague with mortalities rising to 50 per cent of the total population. What little there was to be done had to be arranged on the spot. The parish priest had the task of pronouncing diagnosis and arranging for the isolation of affected households. In some cases an order prohibiting travel was imposed to prevent further spread of plague. More chronic conditions provided scope for institutional care and many hospitals were built for the treatment of specific illness.

Architecturally the hospital resembled the monastery (Gilyard-Beer 1958) and with good reason; in the early Middle Ages the sole source of educated men was the monastery and hospital staff was drawn from this source: indeed, the hospital was usually founded as an off-shoot of an abbey or priory. The monastic ground plan was the only precedent which existed for the designer of the hospital and the arrangement has only one disadvantage; it is wasteful of space, but this was seldom a problem during the period in question. The monastic ground plan takes account of the principles of hygiene and stands up to modern scrutiny. Drains were stone lined and so generously provided that men of later centuries guessing their use concluded they joined male to female establishments by direct and discreet routes. Owen (1955) refers to a local tradition that secret passages existed at Kirkstall Abbey and where it has been possible to identify these passages they have proved to be conduits. Water for irrigation of drains as well as for washing and machinery was provided from an upstream level usually regulated by a weir or a dam. The building was so sited that a stream ran past the south range and the general direction of the drainage within the buildings was from north to south leading finally to the stream. If the water supply was likely to be seriously contaminated, a separate washing and drinking supply would be obtained from a different source or a point higher up the stream, and piped in, if necessary from a great distance (Burne 1962). Provision was also made for collection of the admittedly ample rain water from the roofings. One way or another reasonable pressure of water was obtained at first floor level to supply washrooms and flushing lavatories. Brass taps from such a supply have been found at Kirkstall Abbey (Owen) and the details of a piped water supply are still to be seen at Mount Grace Priory, Yorkshire (Ministry of Works 1959).

Buildings were grouped around open squares of lawn to form cloisters, with covered and sometimes glazed arcades. Each side of the square gave access to the buildings and ideally the height of the buildings was arranged so that the cloister received protection from the wind and the weather, whilst admitting sunshine from the south. If extra buildings were required a covered way was built to connect a new cloister. The design of the hospital was the same whether remote from, or physically attached to, a monastery but the detached

establishment always incorporated some conventual buildings.

The majority of hospitals were provided for leprosy which was prevalent in the early middle ages, although the incidence steadily decreased. It is surprising that it was correctly considered to be contagious, despite an incubation period of several months. It was the duty of the parish priest to confirm the diagnosis, arrange for notice of isolation to be given, and to facilitate admission to a suitable institution (Clay 1909). Fifteen days notice was given to new patients to prepare for withdrawal from the community. A wrongly-diagnosed patient could take legal action and Clay instances an example of this in the parish of Sparham in 1433. Once committed the leper had to wear a uniform, from a distance not unlike that worn by members of the Klu Klux Klan. In addition, audible warning by a clapper had to be given if the leper was accidentally approached by any non-leprous person. Accommodation was usually in multiple single rooms arranged round a cloister. Dormitories, with beds down each side, giving an appearance not unlike the less well equipped hospital of today, were also used (Godfrey 1955). The later trend was towards the sub-division of large rooms or in the case of Thetford Priory, Norfolk, the use of a group of smaller buildings. This suggests that even in the middle ages the open ward was considered second best.

It is likely that some severe skin diseases were regarded as leprosy. A patient whose skin became clear was allowed to return to normal life. With the decrease in leprosy, hospitals became available for other purposes, particularly for what would now be called geriatrics. There appears to have been considerable pressure on beds. Contemporary accounts and illustrations indicated that several patients might occupy what in fairness would now be considered to be a very large bed (Walker 1954). That this over-crowding was not always the case is borne out by documentary evidence of very high standards in some establishments. Clay records that inspections were carried out to ensure that clean linen was provided. The reverse of the coin was provided by the patient who made a bequest "to amend the beds".

Idiosyncracies of particular patients were accommodated where possible. A requisition from the infirmary attached to Westminster Abbey gives an instance of this, when a patient said he could not drink beer. The prior of Westminster Abbey authorized the substitution of wine for beer for this patient only. The accounts show that ten shillings was spent in getting the wine (Crossley 1949).

When the aged or infirm patients were not in need of daily care, they could be accommodated in long-stay units. These were often single rooms. The arrangements varied from inpatient hospital care with full board, to self-contained suites, no meals provided, and

only the Church in common. This type of accommodation would be ideal for pensioners, and the idea of age retirement with financial security was well established.

It was possible to purchase a pension by annual payments, in very much the same way as an annuity at present (Moorman 1946). Pensions were awarded to staff and servants of institutions as rewards for long service. In order to produce income, monasteries could offer pensions to local gentry. Moorman quotes numerous examples. The Hundred Years War and the Wars of the Roses doubtless reduced the burden of the insurers. The pension could take the form of board and lodging in a monastic or a purpose-built hospital. The latter were almshouses some of which survive today.

Midwifery was practised in mediaeval hospitals. Presumably domestic reasons led to some mothers being unable to obtain a home confinement, since no medical indications for hospital confinement are known for this period. Such cases were mixed in with the general intake of patients. Many hospitals had the gloomy provision that if the mother was survived by the baby, the baby would be brought up by the hospital until the age of seven (Clay).

Pilgrims, tourists and those visiting the area on business, were accommodated in guest houses. A proportion of the visitors would fall ill and require treatment on the spot; indeed, some were ill on arrival having made the pilgrimage in the hope of regaining health. A large abbey with a high turnover of visitors and pilgrims would produce experienced physicians. One such was St Guthlac, of Croyland Abbey, who is shown in a manuscript illumination (Leigh 1957).

Better known was the consultant physician to William the Conqueror, Abbot Baldwin of Bury St Edmunds. Arfast, Bishop of Norwich, was his patient as well as his superior, and received treatment for a penetrating injury of the eye at St Edmunds Abbey (Rowe 1958). Cautery and collirums were used but the bishop thereafter had a small corneal opacity. It is also recorded that the abbot refused to begin treatment until a fee had been agreed. Had the condition required surgical treatment, which in this period would be synonymous with the spilling of blood, a surgeon would have been called in from the town since this craft was considered beneath men in holy orders (Coulton 1938). The tendency for physicians to consider themselves more academic than surgeons has persisted almost to modern times.

Casualties and acute illnesses were not the intended main task of hospitals within monasteries, which were for the most part intended for the monastic inhabitants. During the early middle ages the average monastery could not afford good fare and the rule of St Benedict forbade all but the strictest diets. The kitchens and all the

domestic arrangements were designed around this frugality but it was soon realized that there were legitimate indications for amelioration at times. For example old or infirm monks were not expected to share the full rigour of the monastic rule. The infirmary was that part of the monastery devoted to the provision of medically indicated easements and was used on an inpatient or outpatient basis according to needs (Cook 1961). The infirmary was also the place where healthy members of the community were occasionally permitted to break the otherwise strict routine by feeding on such luxuries as red meat. These relaxations must have been an important part of the management of the community and their absence would probably have lowered general fitness.

Unfortunately for the monks and for our opinion of their physicians, routine visits to the infirmary were also made for blood letting. This was one of the many unhelpful medical procedures which appear to have been punitive in effect if not in intention. Bleeding was considered formidable enough to handicap the patient for several days and a period of enforced rest followed it (Dickinson 1961). The rest would be of value in its own right.

These activities must have taken most of the monastic physician's time but the case load of purpose-built hospitals was vastly different. A list of the admissions to St Bartholomew's Hospital, Smithfield, survives for a period from about the end of the fourteenth century. Examples quoted by Clay include 'remedie of his akynge hede', 'bleridness of eyen', 'ryngyng of his eyrs' as well as epilepsy, dropsy, paralysis, fevers and insanity. Cures were claimed for deafness and dumbness. Turnover is less impressive. It is known that about 900 patients were discharged in a five-year period. On the other hand mortality figures are either remarkably good, or misleading, for of these only 92 were deaths. This hospital has been providing continuous general medical care, broken by only two years, since 1123.

At York part of the outline of a similar typical mediaeval hospital can still be seen: St Leonards Hospital lies within the city walls, and the ruined remnant is open to the public. It was staffed by Augustinians; that is canons drawn from priories following the rule of St Augustine. There was a master, 13 canons, four chaplains, eight sisters in holy orders and 206 patients. The hospital did not restrict itself to the treatment of any one disease. One sister had charge of babies and delicate children. Two cows were kept for the exclusive use of the paediatric section (Knowles and Hadcock 1953).

Special provision for the insane has always been made by some hospitals, for instance that dedicated to St Mary of Bethlehem in 1247. The accommodation there has not always been ideal: it must have been noisy and confused at times because it gave birth to the

word 'bedlam', which is a corruption of its name. Known locally as St Mary Bedlam it was moved to another site in 1814 and is still in use.

A tradition of free at the time treatment and old age relief was firmly established in mediaeval England. It lasted for over 400 years and was largely abandoned about 400 years ago during the process of the Reformation and has recently been in the process of restoration. Whatever one thinks of mediaeval society and of the reasons for reforming it, there existed in it a powerful desire to help the afflicted. This desire was expressed in practical terms, at times most generously and effectively. Making full allowance for the difference in resources it compares well with what we have today.

REFERENCES

Burne, R. V. H. (1962). *The monks of Chester*, London. S.P.C.K.
Clay, R. M. (1909). *Medieval hospitals of England.* London. Methuen.
Cook, G. H. (1947). *Medieval chantries and chantry chapels.* London. Phoenix House.
Cook, G. H. (1961). *English monasteries in the middle ages.* London. Phoenix House.
Crossley, F. H. (1949). *The English abbey.* London. Batsford.
Coulton, G. G. (1938) *Mediaeval panorama.* Cambridge. Cambridge University Press.
Dickinson, J. C. (1961). *Monastic life in mediaeval England.* London. Adam & Charles Black.
Gilyard-Beer, R. (1958). *Abbeys.* London. Her Majesty's Stationery Office.
Godfrey, W. H. (1955). *The English almshouse.* London. Faber & Faber.
Hope, W. H. St J. and Bilson, J. (1907). *Thoresby society*, **16**, 60.
Knowles, D. and Hadcock, R. N. (1953). *Mediaeval religious houses of England and Wales.* London. Sheed & Ward.
Leigh, D. (1957). *Med. hist.*, **1**, 237.
Ministry of Works (1959). *Mount Grace Priory.* London. Her Majesty's Stationery Office.
Moorman, J. R. H. (1946). *Church life in England in the thirteenth century.* Cambridge. Cambridge University Press.
Owen, D. E. (1955). *Kirkstall Abbey.* Leeds. E. J. Arnold.
Rowe, J. (1958). *Med. hist.*, **2**, 253.
Williamson, R. (1957). *Med. hist.*, **1**, 51.

ERRATUM

General medicine in the danger zone?

The third sentence of this article should have read " . . . The Norwegian Medical Society sees no alternative to the general practitioner who knows the patient and his family and has not to start every time afresh, who sees the whole man." Our apologies are tendered to the author.