Hospitals and the Deserving Poor in Medieval England

by

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Acknowledgements

“There are some things you can't share without ending up liking each other, and knocking out a twelve-foot mountain troll is one of them.” J.K. Rowling, *Harry Potter and the Philosopher’s Stone*

This thesis had been my troll in the dungeons for the past eight months, and now that it has finally been defeated, I am fully able to appreciate the immense value of living with such a wonderfully supportive group of human beings. Without their humor, love, baked goods, family dinners, and late-night murder mysteries, I would never have completed this project, much less felt as at home here as I have. To Isabel Alter, Anna Bisikalo, Luke Schissler, and Heidi Westerman: more thanks than I could ever say. I want to thank my infinitely patient advisor with whom I worked on this project, Professor Clark Maines. It is nothing less than the truth that without his solid guidance, insightful comments, and skill at encouraging me onwards past tough spots and self-doubt, this thesis would not exist. I also want to thank Professors Jesse Torgerson, Melissa Katz, Marco Aresu, Joseph Fitzpatrick, and Samuel Garcia, for even the briefest of discussions about this thesis helped give me the confidence to continue reading and writing.

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Introduction

“The old hospitals were in no way different from houses of correction. The sick, the poor, the prisoners who were thrown into them were always seen as sinners struck down by God, who first had to expiate their sins. They suffered cruel treatment. So terrible a charity appalled people.”

The phrase “medieval hospitals” invites unflattering comparisons between the medical facilities of our modern-day society and the relative medical ignorance of the European middle ages. This might be rather accurate; after all, there was no precise knowledge of the bacterial, viral, or genetic causes of disease. Even so, this is a fundamentally unhelpful and uninteresting way to conceptualize this period of history. The word hospital itself is in part to blame, for the many hospitals founded between the 11th and 15th centuries in Europe shared few of the characteristics that we associate with hospitals today. These were institutions dedicated to ameliorative methods of healing and hospice care, often focused on specific groups within the population such as elderly priests, the blind, and lepers, to name only a few. Most importantly, however, hospitals were loci of charitable giving within communities, working to fulfill the vital Christian duty to care for the poor and the sick. And they were certainly not places of darkness and despair. This thesis aims to explore medieval charitable practice, hospital design and its evolution, and urban self-expression to reach a comprehensive understanding of what role hospitals played within a medieval city, including how they can enrich our understanding of communal attitudes towards poverty. I will argue that to answer specific questions

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relating to the spatial design, variety, and evolution of hospitals it is necessary to approach them through considering medieval charitable practice and urban societies.

Chapter 1 analyzes the development of Christianity’s relationship with poverty and charity, looking at scripture and works by medieval theologians to argue that a formidable reciprocal relationship existed between the charitable giver and the recipient of charity. Of particular importance to this relationship was the identity of the person receiving charity. Physical suffering was understood to endow a person with greater religious importance, for it formed a connection between their lives and the life of Christ. Thus, the indigent were ideal charitable targets. Determining an appropriate target of charity was, however, more complicated. What populations were the most deserving? For charitable capability was limited, and not everyone who needed aid could receive it. Sickness and infirmity became important identifiers of the ideal charitable target. Chapter 2 is wide in scope. In order to talk specifically about individual hospital foundations, it is necessary to understand the variety and development of hospital foundations in medieval Europe. This chapter looks at the diverse range of hospital types, from their physical layout to their inhabitants, to provide useful examples for comparative analysis. Monasteries feature prominently in this section, as they are unarguably architecturally and organizationally connected to many hospital foundations. Chapter 3 argues that in order to fully understand how a medieval hospital was understood by its community one needs to look at the urban societies of medieval Europe, and how they understood themselves. Hospitals were primarily urban foundations, and by looking at a specific urban center, in this case
York, it is possible to gain a more complete understanding of many of the elements discussed in the preceding chapters. The location, patron, and target population were all intertwined with the significance of belonging to an urban community. Chapter 4 focuses on leper hospitals and leprosy, using the hospital of St Nicholas, York, as a prime example. Leprosy is a rather infamous disease, and the conventional understanding has been that those suffering from it were segregated from the rest of society. In fact, while leper hospitals were placed outside city walls, they were, along with their inhabitants, understood to be important features of urban communities. This chapter analyzes how and why leper houses were founded, and in what manner people in York’s community and other similar towns interacted with these foundations. Chapter 5 continues to look at hospital foundations in York, namely St Leonard’s, one of the largest and wealthiest hospitals in England. As a powerful religious institution, this hospital had significant rights within York’s community, enforcing laws and collecting rents in the area it controlled. This chapter looks at how York’s citizens interacted with large and small hospitals, as well as analyzes the reasons behind the increasing popularity of local hospitals.

Much has been written about the European middle ages, and especially the medieval history of England. Despite the wealth of scholarly research for this period, medieval hospitals remain lightly studied. One reason for this is the lack of physical and documentary remains for most of these foundations; they were often small, poorly endowed, and liable to last only a few generations. Even so, they constituted a sizable proportion of religious foundations in England and deserve more focused
attention. Regarding English hospitals, the most well-known survey was published in 1909 by Rotha Mary Clay, _The Mediaeval Hospitals of England_. This book remains useful despite its age for it is comprehensive and well-researched, providing information on numerous facets of hospital foundations. Clay also includes a translation of a ritual of seclusion for a person with leprosy which has been continuously cited up until the present day. Another useful survey is that of Knowles and Hadcock, _Medieval Religious Houses: England and Wales_, published in 1953. These two works, along with the volumes of the _Victoria County History_, are the major sources for locating and identifying hospital foundations, but they are, especially Knowles and Hadcock, focused on description and identification rather than analysis. A number of books on the history of the city of York were consulted as well. The most recent, _Medieval York: 600-1540_ by D. M. Palliser, was published in 2014. These are all surveys, and thus help provide spatial context throughout this thesis, but do not go into serious analytical depth. Palliser’s work contains the most up-to-date archaeological information, making this work highly useful to this thesis.

In the late eighties and nineties, a number of scholars began to look more deeply and critically at hospital foundations and charitable giving in medieval England, namely Miri Rubin, Patricia Cullum, Carole Rawcliffe, and Nicholas Orme and Margaret Webster, writing _The English Hospital_ together. These works are particularly useful for they offer a re-analysis of Clay’s work, updated in view of more recent archaeological and historical publications. The authors, especially Carole Rawcliffe, work to present the hospital in its historical context and surroundings, allowing for a more in-depth exploration of hospital foundations. This thesis is deeply indebted to
most of these publications, for they not only provide a wealth of comparative material but also offer useful analyses of numerous aspects of hospital design and function. Of particular importance to this thesis is Rawcliffe’s *Leprosy in Medieval England*. It challenges the conventional understanding that lepers were cast out of medieval communities, and that leper houses were places of isolation and segregation. In doing so, Rawcliffe allows leper hospitals to be understood as places of community engagement and spiritual power. And in *Urban Bodies: Communal health in late medieval English towns and cities*, her brief analysis of hospitals nevertheless touches their importance within the spiritual and physical topography of English cities. It is also important to mention the work of Michel Mollat, especially his comprehensive *The Poor in the Middle Ages*. The scholars listed above deal with the poor as well, for they were the primary inhabitants of medieval hospitals, but Mollat offers a valuable chronological analysis of medieval attitudes towards poverty. One of the major areas of uncertainty in the study of hospitals and charitable giving in medieval Europe relates to the development and change in the practice of giving charity. Miri Rubin’s *Charity and Community in Medieval Cambridge* and Mollat’s *Poor in the Middle Ages* both argue that there was a pronounced change in attitude towards the poor after the black death, leading to increased hostility and decreased patronage of hospitals in the 14th and 15th centuries. Patricia Cullum’s doctoral thesis, *Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547*, challenges this conclusion, pointing out that while older hospital foundations may have been hard-pressed financially, wills from these centuries reveal that charity was commonplace, rarely absent from these documents. Cullum also deals with lepers, noting the importance of
*leprosaria* in determining the prominence of urban centers in England. However, her analysis remains at a superficial level, and lacks a serious analysis of the social and spatial significance of these hospital foundations. This thesis seeks a synthesis of sorts, combining the more complex and analytical work of Rawcliffe with the comprehensive study of York’s hospital foundations in Cullum’s scholarship.

The primary sources available for this period are quite varied. From the Norman conquest to the end of the 12th century, the main sources are charters and chronicles. These can provide valuable information regarding the foundation of hospitals, but little about their internal organization or continuing community support. In the 13th century, a number of new sources appear. Records of visitations, indulgences, and patent and close rolls elaborate on the internal mechanics of hospitals. The 14th and 15th centuries mark the growing presence of wills and probate inventories, allowing for an examination of individual charitable practices. Civic records also became available during these centuries. Some primary sources are used in this thesis, namely a small collection of probate inventories and wills, but many remain either in England or in their original language. An ability to read Latin and old French would have been invaluable, although I have tried to use secondary sources which reproduce in translation some of these documents. Chapter 5 makes heavy use of Patricia Cullum’s doctoral thesis on the hospitals of Yorkshire for it remains the

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2 Patricia Cullum notes that the surviving wills from this period were mainly from urban centers even though in this period the majority of the population was still rural. This suggests that wills were rarer in rural areas, or that the chances of survival were better in towns. Either way, more records exist for urban charitable giving, making a city-focused thesis sensible: Patricia Helena Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547” (University of York, 1989), 10.
definitive source on medieval hospitals in this area of England. Her access to the wealth of documentary sources in York makes this work, *Hospitals and Charitable Provision in Medieval Yorkshire*, invaluable for any investigation of this topic. I have tried where possible to diversify my sources, a task hampered by the lack of more recent scholarly research on York’s hospitals.

This thesis cannot touch on every facet of medieval hospitals, and I have made the decision not to discuss pilgrimage and its relationship to hospitals in medieval Europe. Pilgrims were part of the diverse group that would have found lodging in some, though not all, hospital foundations. Large hospitals which provided temporary shelter to the poor also would have taken in some travelers and pilgrims. And hospitals were often located on busy roads, by bridges, and at important crossroads, well placed to cater to travelers. It is certain that pilgrims would have made use of these institutions during their travels, but necessarily not to a large extent. Hospitals were often wary of letting in pilgrims and travelers; the great hospital of Paris, the Hotel-Dieu, had specifically banned pilgrims from receiving its hospitality by the 14th century, and possibly earlier. Pilgrims, the poor, and the sick were often overlapping groups; relics, especially those held at important pilgrimage centers such as Canterbury, were understood to have healing properties. However, hospitals were not, for the most part, aimed at care for pilgrims. As they are tangential to the main

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3 Geremek, *The Margins of Society in Late Medieval Paris*, 171. Geremek also notes a 15th century poem (his italics): “Mon pourpoint tout neuf coutonne, / Qui ne m’a servi que neuf ans, / J’ordonne et veux qu’il soit donne / Au roy des Pellerins passans / Lesquels on appelle truans / ou coquins…” The suggestion that pilgrims had a king is fascinating, but more important to note is that pilgrims are grouped together with rouges and vagabonds.
4 Some larger foundations hosted great numbers of pilgrims – one of the most well documented cases being Santa Maria della Scala in Siena. *Siena: City of Secrets* by Jane Tylus notes the importance of
concerns of this thesis, and deserving of in-depth study themselves, they will not be discussed in this work.

Also outside the scope of this thesis is the infamous plague, or Black Death. While this might seem odd, hospitals in medieval Europe were not centers for treating infectious disease. In fact, most if not all hospitals would have specifically banned those who were suffering from diseases similar to the plague. Medievals were quite aware that these types of disease were contagious, and although they did not know exactly how they spread, close contact with the sick was to be avoided. In 1439 during the reign of King Henry VI of England the parliament at Westminster excused the king’s vassals from performing the customary kiss of homage because of “a sekness called the pestilence, universelly thorough this youre roialme more comunely reyneth, than hath bien usuell bifoire this tyme, the whiche is an infirmite most infectif.” Hospitals were not equipped to tackle these diseases, most of which were fast-acting and deadly. Rawcliffe’s *Urban Bodies* offers a comprehensive analysis of the ways in which urban communities attempted to tackle these outbreaks.

Lastly, a note on dates. The reformation and Henry VIII’s program of monastic dissolution between 1536-1541 will serve as an endpoint for this thesis. No precise starting date can be used, although the 12th century was the real beginning of
the surge in hospital foundations in England. There is some attempt to phase hospitals, such as the acknowledgement that most almshouses and *maisons dieu* were founded from the 14th century onward. These century dates are always an approximation, for it is easy to find a hospital which defies these general conventions. I considered and rejected using phrases such as “later middle ages” or “high middle ages,” for they are little more than general terms for century divisions, which I prefer to make explicit. Also, they are less applicable in English scholarship, where it is common to speak of the Anglo-Saxon period until 1066 and the medieval period after. Medieval and middle ages will be my terms of choice, as they are general but more transparent for readers without a background in medieval studies.
Chapter 1: Conceptualizing Poverty and Illness

From its earliest origins, Christianity has been intimately concerned with the concept of poverty. This remained the case in the middle ages, as theologians grappled with the complicated legacies left by early Christian thinkers on charity and poverty. In chapters eight and nine of the Second Epistle to the Corinthians members of the community are exhorted to give alms for the poor: “For ye know the grace of our Lord Jesus Christ, that, though he was rich, yet for your sakes he became poor, that ye through his poverty might be rich.” This passage from Second Corinthians not only identifies Jesus as poor, which by itself lends poverty a powerful religious significance, but it then takes a further step: poverty is a path to richness – not material but spiritual richness. This is reversal of the reality of poverty, which can be generally understood as a condition of lacking in material wealth. Here, the understanding of poverty is this transformation from loss to a greater gain, and it is a recurrent theme in the Bible. “And he lifted up his eyes on his disciples, and said, Blessed be ye poor: for yours is the kingdom of God. Blessed are ye that hunger now: for ye shall be filled. Blessed are ye that weep now: for ye shall laugh.” The same transformation occurs in Luke, as the poor are those deemed most spiritually rich. However, there is one major difference between Luke and Second Corinthians. In Luke, the poor are defined as a separate group, and to this group belongs the kingdom of God. Those who are not poor are excluded from this relationship. Second Corinthians brings them back in, Jesus’ poverty translating into spiritual richness for

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6 2 Corinthians 8:9.  
those who accept his teachings. Jesus’s poverty in this sense functions as a path to spiritual richness for others. The language in these verses is complicated, for both poverty and richness have contrasting meanings. Spiritual richness is praised; material richness is condemned. “Then Jesus said to his host . . . When you give a banquet, invite the poor, the crippled, the lame, the blind, and you will be blessed. Although they cannot repay you, you will be repaid at the resurrection of the righteous.”

Those who are poor in material wealth do, in fact, repay those who embrace them, for they provide spiritual benefits. And since material wealth is condemned, material poverty, its opposite, is praised. These verses, while not condoning the accumulation of wealth, do not firmly deny that those who possess material wealth can achieve spiritual richness. Through emulation of Jesus, who made himself poor through sacrifice for others, those who are not necessarily poor can reap spiritual benefits; but the materially rich can also, as Luke 14:14 suggests, use their wealth in ways that are spiritually beneficial.

This relationship between poverty and wealth is central to the development of Christian thought. The materially wealthy were under an obligation towards paupers and other marginalized classes. “Ambrose was quoted in the Decretum to confirm the view that a rich man was not free to dispose of his goods at will, but that he should employ his superfluous goods in the help of others. This view accepted the existence of rich and poor but placed the former under an incessant obligation to help the

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latter.” This responsibility that Rubin mentions is the result of the fleshed-out doctrine surrounding the ideas put forth in Second Corinthians and Luke. Care for the indigent is a path to spiritual wealth. Early Christian thinkers, like Saint Ambrose, Augustine, and Anthony the Great were intimately concerned with poverty and the proper relationship of the wealthy and the poor. The life of Saint Anthony records an event in which “he went into the church pondering these things [the apostles selling their goods], and just then it happened that the Gospel was being read, and he heard the Lord saying to the rich man, “If you would be perfect, go, sell what you possess and give to the poor, and you will have treasure in heaven” . . . immediately Anthony went out from the Lord’s house and gave to the townspeople the possessions he had from his forebears.” Saint Jerome taught that “the widow who borrowed money in order to give alms was simply following the example of Christ.” In both these examples, there is a deliberate impoverishment by one who has material wealth in order to come closer to spiritual wealth. Charity is thus the means through which those with property can interact in a spiritually beneficial way with those without.

“Jesus Christ compared love of neighbor with love of God; proclaimed as its prototype the love of the Heavenly Father and His own reclaiming love for all

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mankind... in the doctrine and example of Jesus Christ lie the germs of all the charitable activity of the Church.”

It is important to note that two different meanings of the word poverty have been mentioned so far. Poverty in a material sense, and poverty in a spiritual sense. Mollat argues that the first was that person who “is indigent and in need of material assistance” and the second found in “the attitude of one... inwardly humble and ready to do God’s bidding.” These two senses are by no means opposed. Christ embodied both aspects; but in Second Corinthians, spiritual poverty is the important one. In this case, poverty is a lack of pride and arrogance, a willingness to help others, the love of the neighbor, placing the other above the self. This then ties directly into the relationship of the Christian to poverty in the physical sense. Almsgiving and charity is a manifestation of the spiritual poverty that Second Corinthians praises, and thus obligatory for a Christian. “Great care and concern are to be shown in receiving poor people and pilgrims, because in them more particularly Christ is received.” As St. Benedict notes, the poverty of Christ is present in the poor simply through their lack of material property. The benefits of physical poverty in Luke enable Christian thinkers to combine these two senses of poverty. One should imitate the poverty of Jesus; this is both a physical and spiritual humbling. As Rubin again argues, the

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13 Mollat, 21.
obligation to help those in material poverty makes perfect sense, for by aiding those in poverty one can bring oneself closer to the ideal that Christ embodied.\textsuperscript{15}

This dual meaning contained within the idea of poverty remained just as critical in the medieval period. There was, however, an important expansion of terminology relating to poverty and the poor that is critical for understanding their treatment in the middle ages. In his introduction, Mollat argues that “the catalogue of terms used to describe poverty, many of them ambivalent, is notable for its variety and susceptibility to change,” reflecting “the spread and aggravation of misery and growing awareness of its effects.”\textsuperscript{16} Similarly, Rubin notes that “Le Goff argues persuasively that in twelfth-and-thirteenth-century society, and mainly the urban milieu, new schemes of social, moral and political classifications came to replace conservative dualities . . . people came to think in the more sophisticated terminology of a more differentiated and varied society.”\textsuperscript{17} These two arguments share important points. Both agree that the changing conception of poverty was based on changing social conditions. And both are suspect, for they make sweeping generalizations about the mentality of the European medieval world. Was medieval Europe, that loose grouping of roughly a thousand years, truly growing more miserable? With this in mind, Rubin’s use of Le Goff is clearer, that these changes were not simply an increase in misery but social changes which necessitated a diversification in classification surrounding the concept of poverty. To put it simply, there were

\textsuperscript{15} Rubin, \textit{Charity and Community}, 59.
\textsuperscript{16} Mollat, \textit{The Poor in the Middle Ages}, 1.
significant changes in the way poverty was understood and classified, which meant that the language used varied in important ways. “The localized nature of the ever-present existence at subsistence level in earlier centuries, rendered it almost invisible, but now,” after around the year 1000, “it was giving way to a more complex social and economic reality . . . towns attracted migrants from an ever-more populous countryside to create a large supply of labour which subsequently produced falling wages and urban indigence.”¹⁸ Urban centers’ growing prominence is a key factor in the changing conceptions of poverty, and central to the development of foundations aimed at aiding paupers. As poverty became more visible and more immediate, the result of a concentration of population in a small urban area, new ways of conceptualizing this population were needed. The increasing use of the vernacular from the thirteenth century onwards provides many examples of how words relating to poverty changed through the centuries. “The words functioned as adjectives before being used as nouns. Originally, a person was poor (pauvre) but later he or she became a pauper (un pauvre). Poverty first referred to the quality, then to the condition of a person subject to some deficiency, regardless of social status . . . inequalities thus emerge within the shared condition of poverty.”¹⁹ This argument of Mollat’s is useful when considering the earlier divisions of material and spiritual poverty. If people of different social classes could be called poor - laborers, farmers, knights, priests – despite clear differences in actual wealth, then defining the spiritual ideal of material poverty seen in Luke becomes increasingly complicated. Poverty was a relative matter, and thus it was now necessary to define for the Christian to

¹⁸ Rubin, Charity and Community, 8.
¹⁹ Mollat, The Poor in the Middle Ages, 2.
which poor person alms should be given. “The poor were defined not in economic but in political and legal terms: they lacked power. They might include ‘poor knights’ and ‘poor priests,’ who had lower incomes than their fellows, and had difficulty in maintaining their status.” The dilution of a purely economic definition of poverty is critical, for it ushers in a concerted effort to categorize and define the poor by type and suitability for charitable actions.

This increased emphasis on categorization and division of the poor manifested itself most influentially in debates over who among the poor were deserving of charity and aid, and who should have been able to pull themselves out of poverty. “Men like Bernard of Clairvaux and Peter of Blois used the pair egenus and pauper; the two words were not synonymous but had specific and different meanings. Pauperes, for these writers, referred to a group of the wretched for whom material assistance was required as a matter of justice. Egenus traditionally referred to a category composed of needy individuals, orphans, widows, and pilgrims.” These divisions became increasingly important as the population of Europe expanded, expanding cities, putting strain on agricultural production, and creating larger, and importantly, more visible numbers of poor. As the main force driving charity and almsgiving in the Middle ages, the church was intensely aware of the difficulty in defining the poor. When the bible says that the poor are blessed, who are these poor?

21 Mollat, The Poor in the Middle Ages, 4.
Bernard of Clairvaux and Peter of Blois\textsuperscript{22} use a variety of terms because they recognize the impossibility of gathering the entire group under one label. There was simply too much variation in people’s economic and physical conditions, and as those could be labeled as poor expanded in the thirteenth and fourteenth centuries it placed a heavy burden on charitable institutions. “The growing number of poor . . . put the traditional doctrine of charity under great strain. The existing mechanisms, that is the ecclesiastical institutions, revealed themselves to be completely inadequate, even though the protection of the deprived remained one of the principal temporal missions of the Church… charitable initiatives multiplied outside the Church, encouraged by the preachers; charity became one of the most highly-lauded virtues.”\textsuperscript{23} Geremek mentions that the traditional doctrine of charity was put under strain in the mid-fourteenth century, but even before this the church was struggling to define for whom they were required to provide. The \textit{Decretum Gratiani}, a twelfth-century collection of canon law, and its subsequent commentaries wrestle with the church’s obligation towards the poor, attempting to divide them into groups deserving and undeserving of charity.

Many commentaries on the \textit{Decretum} focus on this issue of poverty because Gratian, the compiler of the \textit{Decreum}, intentionally left contradictions in the legal code. “Gratian himself did not harmonize all the "discordances" in the great collection of texts that he assembled,” instead, he “presented an excellent selection of texts

\textsuperscript{22} Bernard of Clairvaux (1090-1153) was the founder of the Cistercian order, a reformed Benedictine order. Peter of Blois (c. 1030-c. 1211) was a French theologian and diplomat, active in England under King Henry II.

\textsuperscript{23} Geremek, \textit{The Margins of Society in Late Medieval Paris}. 
bearing on the subject but did not explain how they were to be reconciled with one another.”

The difficulty for Gratian was that there were canonical Christian texts arguing for indiscriminate charity and many also campaigning for discriminating between the poor. Gratian, citing a text of St. John Chrysostom which explained “that if a stranger presented himself as a priest he was to be examined, but that normally a man who simply asked for food was to be helped without question, for it was not the deserts of the recipient but the generosity and goodwill of the giver that counted in the sight of God.” This argument lies directly opposed to a teaching of St. Augustine, who argued “that no alms were to be given to followers of infamous professions: actors, prostitutes, gladiators,” requiring an act of judgement on the part of the giver before the act of charity. Gratian also twice quoted Augustine’s teaching that “it is more useful to take bread away hungry man than to break bread for him if, being sure of his food, he neglected righteousness.” In direct opposition to St. John Chrysostom, St. Augustine allows the giver of charity to withhold charity unless the giver is certain that his or her gift will not corrupt the recipient. He even appears to condone forcibly preventing a pauper from acquiring goods based solely on a prediction of his future actions. Clearly, not everyone in need is deserving according to the teaching of St. Augustine. One must decide who is deserving of charity, for it is not simply an act that benefits the giver, but one that includes both parties. Two commenters on the Decretum, Teutonicus and Rufinus, both came down on the side of Augustine. “The Church need not provide for those who can work. One must take

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25 Ibid.
into account wholeness of body and strength of constitution when alms are dispensed,” agues Teutonicus, while Rufinus suggests that “four factors were to be considered - the quality of the person seeking alms, the resources of the giver, the cause of the petition and the amount requested. In the first place the beggar was either honestus or inhonestus. If he was inhonestus and especially if he was a man capable of working who preferred rather to beg and steal, certainly nothing was to be given to him but he was to be corrected (unless he was actually dying of hunger). The conflation of begging and theft merits discussion. To modern eyes, these are far from equal. But, as will be seen in chapters four and five, begging was understood to be an act that defined those who were deserving of charity. Giving charity was a reciprocal act: both actors benefited for the giver received spiritual compensation. A false pauper did not have the same spiritual significance, thus stealing the potential benefit from the giver. “If the resources available were sufficient then all the honesti could be helped, but if there was not enough for all, then the rules of St. Ambrose regarding discrimination in charity were to be adopted.” Ambrose stated that one should “love first God, then his parents, then his children, then those of his own household and finally strangers.”27 Both commenters agree that there is a group of poor who, while they may be lacking and in need, do not deserve any charity. A beggar needs to fulfill certain conditions in order to be deserving of alms, and these necessary characteristics must in some way render the beggar or pauper unable to make a living. Unable is a generic descriptor, however, and this allowed for considerable discretion in deciding its precise meaning. Of course, not all the authors of commentaries on the Decretum

agreed with Teutonicus and Rufinus. The author of the *Summa Elegantius*, written around 1169 C.E., argued “that according to St. Ambrose we ought to help our own before strangers, the sick before the well, the just before the unjust and so on, and that according to St. Augustine it was a sin to give to members of infamous professions,” but “St. John Chrysostom would have us aid all indiscriminately.” As Tierney notes, “his solution was based on the donor's knowledge of the applicants or lack of it. If he did not know anything about their way of life he was to give to all provided that his resources sufficed; if he did know them and he had not enough for all, then the usual system of preferences was to be applied.”

While this commenter agrees that one can divide the poor into groups with varying levels of need, he does not identify a group of needy who should never be given alms. Even those who might have chosen to beg are still deserving of charitable giving, and the donor is not justified in making judgements about those people he or she does not know. In this case, one is required to give to all unless financial circumstances prevent it, in which case the more deserving are to be helped first.

The commentaries on the *Decretum* are in general agreement that the act of charity was a mutually dependent relationship. It was not solely an act that hinged on the giver, for the status of the recipient mattered. Charity was a connection between the haves and have-nots, a reciprocating relationship, and when the givers grew distrustful of the poor it caused a “creation of alternative forms for the exhibition of piety, and the development of a social theory which would rationalize their

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unwillingness to alleviate the real poverty around them. By reasoning that the poor were sinful, unruly, lazy and generally undeserving, by dispossessing the poor from the title *pauperes Christi*, an understanding could be effected which liberated those better off from responsibility for relief.”

If a group of paupers were judged able to work, then there was considerable doctrinal support for refusing to give them any charity at all. And even then they were not as deserving as others, such as friends and relatives, whose care was generally agreed to come first. The issue of able-ness was absolutely critical, and defining the poor who were able to work was at the forefront of Medieval thought on charity. One can see traces of attempts to divide and categorize the poor in “those very wills which nevertheless aimed to secure atonement for sin by legacies to the poor; they asked for beggars to be selected who were genuinely unable to work.”

As Rubin argues, the reciprocal relationship between the giver and the recipient of charity was threatened by this category of poor. Alms that went to these people were understood to be of less value to the soul of the giver, for they benefited from helping the neediest. Who were these people, those physically able to work but who had turned to begging?

“Impoverished peasants and artisans, unemployed wage-earners, those who had been unable to find work, as well as those who had not looked for it, were all ‘false-poor’ who ought not to benefit from assistance or charity. The authentic poor were those for whom work was impossible; that is, the crippled, the sick, the old, widows and orphans. They constituted the approved and acceptable body of people receiving assistance. They alone were entitled to protection, to a place in a refuge or a hospital, to receive alms and to beg.”

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29 Rubin, *Charity and Community*, 10.
In Paris, the poor who were not able to work were the only beggars accepted by the authorities. An ordinance issued in 1351 C.E. “called on preachers and monks to not encourage charity except for those unable to work; similarly, private alms-givers were advised not to give assistance to vagabonds or those who could work.” Civil authorities used the distinctions created by the church to try and control the beggars in the city, attempting to prevent those giving charity in Paris from supporting vagabonds. The underserving poor were not simply refused alms; in their exclusion from the reciprocal relationship between the donor and the recipient, they were seen as a threat to the community.

Due to this effort to categorize and divide the poor, the poor and the sick in Medieval Europe were closely connected. Mollat provides a number of commonly used words in describing destitution in the Middle Ages.

“Shortage of food (esuriens, famelicus) or clothing (nudus, panosus); physical defects such as blindness (caecus), lameness (claudus), arthritic deformity (contractus), infirmity in general (infirmus), leprosy (leposus), injury (vulneratus); feebleness due to poor health or old age (aegrotans, debilis, senex valetudinarius); mental deficiency (idiotus, imbecillis, simplex); temporary weakness affecting women during pregnancy and childbirth (mulier ante et post partum); situations of adversity such as those involving the loss of one’s parents (orphanus), husband (vidua), or liberty (captivus); and finally, banishment and exile (bannus, exiliatus).”

The majority of these words are directly related to a physical condition of ill health, conditions which impose a strong sense of destitution. People suffering from many these conditions, as today, may be more likely to be in economic hardship, but in the

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33 Mollat, The Poor in the Middle Ages, 3.
middle ages, the fact they were undergoing suffering was critical. In his commentary on the Rule of Saint Benedict, the ninth-century monk Smaragdus notes that “he who through compassion shares with a sick person and ministers a counsel of comfort to the distressed is certainly relieving the poor.”

Pecuniary misfortune was not the only reason to give charity. The suffering of the sick made them viable targets as well. Rubin provides a simple but effective definition of poverty that well encompasses the medieval conception of poverty. Well-being is the “possession of... capabilities to function... the capability to function effectively and to maintain some control over one’s environment.”

A state of poverty exists when one cannot function as defined by one’s position in life. This could be economic or, as the list of terms that Mollat provides above illustrates, physical poverty. “Poor hygiene and health are so often linked to lack of economic resources that it can be hard to distinguish between the biological and economic aspects of poverty.” In fact, in many cases, those who were truly destitute were also visibly suffering the effects of illness or some disability, and vice versa. Hospital institutions “were destined for the poor, often called ‘Christ’s poor’ (pauperes Christi). All the foundation records express this function of the hospital in the same way. It is clear that in the ethos of the time, the sick and the poor were indistinguishable; sickness made it possible to

34 Smaragdus et al., Commentary on the Rule of Saint Benedict (Kalamazoo, Mich.: Cistercian Publications, 2007), 186.
35 Rubin, Charity and Community, 7.
36 Mollat, The Poor in the Middle Ages, 6.
benefit from charity, and the term ‘poor’ might describe only the state of health, and not the financial situation.” Geremek’s argument is powerful, for he recognizes the importance of the deserving/undeserving poor distinction. A physical deformity or affliction made the identification of those suitable for charitable donations simpler. The poor and the sick are intimately connected, for poverty, in the Christian definition, was a condition of humility, both physical and spiritual. The suffering brought on by physical illness and deformity was truly humbling.

Poverty and illness are not the same thing. But they were very closely connected during the middle ages. The undeniably central position of charity within Christian doctrine meant that it was a topic of consistent debate and reevaluation by theologians. Demanding the construction of a very specific kind of relationship, charity was not a simple act of giving. Instead, it required a willing donor and an appropriate recipient. Identifying who deserved charity ensured that illness was intertwined with poverty, for it allowed easier identification of the correct recipient. An illness, a disability, a deformity, a specific social position: all of these categories enabled the medieval charitable donor to be more certain that they were not wasting their aid. And thus it is these groups that feature most prominently in medieval hospitals.

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Chapter 2: The Medieval Hospital

The modern understanding of a hospital bears little resemblance to the institution, or, more accurately, the plethora of institutions that would have been called that name in medieval Europe. It was not until the beginning of the 16th century, with the construction of the Savoy in London by Henry VII, that an English hospital had a permanent, salaried contingent of medical personnel. The hospitals that preceded the Savoy in England were a varied group, and historians have posited a number of different categories for organizing hospital foundations. One such list provides the following grouping: “leper houses, almshouses, hospices for poor wayfarers and pilgrims, and institutions that cared for the sick poor.” But this is less useful than it might appear. How does one separate these categories? Carlin suggested a division based on the inmates at each institution. However, large hospitals like the Hotel-Dieu in Paris, St Mary Spital in London, and St Leonard’s in York all cared for a range of inmates, from pregnant women, to orphans, to those who were truly sick or infirm. One could also group hospitals by their physical layout, such as leper hospitals, openward hospitals, and almshouses/maisons dieu. This is simpler and more effective, but every hospital that this thesis focuses on went through numerous evolutions, during which both their form and function changed. Identifying categories and types

38 Rawcliffe, Urban Bodies, 297.
41 These groups will be discussed at length in this chapter and Chapters 4 and 5.
is helpful for making comparisons between institutions, but they do not give an accurate picture of the diversity and complexity of medieval hospitals. This chapter attempts to define the medieval hospital while acknowledging these varied forms and functions, so as to provide context for later investigations of specific institutions and their functions.

There was considerable overlap between the spiritual and physical aspects of health, just as poverty and illness were interwoven in the Christian worldview. During the early development of their religion, “Christians adopted ancient Egyptian and Jewish models of social welfare that targeted particular social groups marginalized by poverty, sickness, and age. Jewish communities had offered hostels to house the poor and sick travelers, and their healers were obligated to treat the sick poor. Houses were even set aside for lepers.”⁴² As was discussed in the previous chapter, Christian scripture identified Christ as the archetypal pauper and imbued charitable care for the poor and sick with hefty religious significance. New institutions were created which provided an institutional outlet for charitable action. “Before the year 330 . . . the Christian church in Antioch and its daughter churches in the Syrian hinterland had already set up hostels or guest houses for the poor called xenodocheia.” In these institutions, the primary goal was the “protection and social control of its inmates. Services were provided with an emphasis on togetherness in a dormitory-type environment. Harsh punishments were recommended for those breaking the rules . . . in addition, to shelter, order, and discipline, these hospitals offered spiritual care,

taking advantage of the inmates’ fears, dependencies, and piety. As an adjunct to churches and monasteries, the institution was clearly defined as a religious space.”

The similarities to early monastic foundations are clear. There was a strong emphasis on the religiosity of a community that, like a community of monks, occupied a spiritually significant place in Christian society. As Risse notes, these early hostels for the poor were focused on their spiritual well-being, not necessarily on their physical health. Houses for the sick were nosokomeion, although in reality these two foundations were essentially equivalent. The aspects and scope of the physical care that these institutions provided: shelter, food, and clothing, persisted relatively unchanged into the medieval period. The charter of a hospital founded at the end of the thirteenth episode in Tonnerre, France, clearly identifies Christ with the poor and the suffering, and identifies the Seven Acts of Mercy as the basis for the regimen of care provided by the hospital. These seven acts are “mainly derived from the Gospel of Matthew (25:34-40). They consist of: feeding those who hunger, giving drink to those who thirst, receiving and sheltering strangers and pilgrims, clothing the naked, visiting and tending the sick, consoling prisoners and burying the dead.” These same Acts formed the basis of physical healing in early Christianity, and were focused on ameliorating the effects of poverty and malnutrition that would have plagued many of those admitted to hospital institutions.

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43 Risse, 82.
44 Ibid.
46 I use this phrase with caution, for it is important to note that while these early hospitals might, in a modern view, hardly qualify as a place of medical treatment, much could be done by providing shelter, food, drink, and rest. Physical healing did take place, but with clear limits on the scope of said healing.
After the fragmentation of the Western Roman Empire, the old urban centers in the west gradually depopulated. They often transformed into ritual and religious centers, centered on the church, controlled by the local bishop. Monasteries, many of which were located in rural areas, also became centers of Christian religious life, and they incorporated the treatment of the sick and care for the poor into their mission.

These were not hospitals in a later Medieval sense. They often had infirmary complexes in the monastic compound, but were not solely focused on care for the sick and impoverished. Charity was vital in Christianity, however, and as religious centers, monasteries also were centers of poor relief. As Risse posits, “monasteries

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47 This is a generalization, but especially in the areas that would become France and Italy, urban centers declined precipitously. Some of this was due to an increased tax burden on city dwellers. War depopulated some areas. But it was also representative of a larger shift in political administration. Many aspects of the empire persisted for centuries after the Western Roman Empire fell, but structures did gradually change, one of which was the taxation system. The network that had allowed the Roman Empire to effectively tax its citizens became less effective, meaning wealth moved from taxes to land, empowering landowners rather than wealthy urbanites. Trade in bulk goods declined as well, forcing large cities to shrink as food supplies became harder to concentrate into a single area. This is obviously a general explanation. Barbara Rosenwein offers a useful overview of the transformation in *A Short History of the Middle Ages* (2009). Chris Wickham’s *The Inheritance of Rome* (2009) offers more details.
rather than decaying episcopal cities assumed the greater role in dispensing welfare.”

The office of the almoner was in charge of overseeing the distribution of resources to the poor, a task that varied in complexity depending on the prosperity of the surrounding countryside. The Plan of St. Gall, created around the beginning of the ninth century, is an idealized representation of a Benedictine monastic community. Despite the fact that it never was completely recreated as a physical monastery, the plan is very much a product of the contemporary understanding of what a monastery should be at the time. The plan stipulates that the monastery should have, near the central church, a building for the lodging of pilgrims and paupers. This facility was overseen by a monastic official, the master of the hospice, who had his lodging nearby. Directly connected to the lodge was a structure designated for the brewing and baking of bread specifically for the visitors and guests in this space. Provision of food, drink, and lodging, as well as likely some monetary charity, was the main set of functions of this space. Horn and Born look to the Administrative Directives of Adalhard of Corbie to gain a sense of the duties of the officers who oversaw this section of the monastery. This “lists the amount of money that should be distributed among the poor, pointing out that no rigidly binding rules could be established in this delicate matter where varying needs require varying action.” (Horn & Born, 151) The infirmary, meanwhile, was located across the monastic compound, and appears to have been primarily intended for the use of the monks. It is simply not clear if medical care at the infirmary would have been provided to the visitors of the

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48 Risse, *The Hospital in History*, 95. Not always the case, of course. In Paris, the bishop founded a hospital attached to the cathedral in the 7th century.
50 See Appendix 1, Plan 1.
lodge. However, this lodge was not far removed from the structure of a large, urban hospital of the later middle ages. The care provided was essentially that of a hospital like the one at Tonnerre. Sustenance and comfort for the poor and sick, not medical attention provided by a physician. Additionally, the physical layouts of both the lodge and infirmary on the Plan of St. Gall have many similarities to those of later medieval hospital complexes. Both complexes on the plan were designed as miniature claustral spaces, especially that of the infirmary, which had its own chapel for the ill, where they could worship without needing to mingle with the rest of the community in the central church. At Tonnerre, the “plans show long ranges and a semi-claustral layout with open courts for the chateau, staff accommodation, and service ranges.”\textsuperscript{51} The larger hospitals of the later medieval period maintained the monastic emphasis on organization around a cloister, although as visible at Notre Dame des Fontenilles, the infirmary hall/main hospital ward is a simplification of the space on the Plan of St. Gall. The dormitory has been combined with the chapel, so that the patients at Tonnerre could participate in the services without needing to leave their beds. The cloister is less clearly defined at

\textsuperscript{51} Courtenay, “The Hospital of Notre-Dame Des Fontenilles at Tonnerre: Medicine as Misericordia,” 95. See Appendix 1, Plan 1 and Plan 2.
Tonnerre as well, but this was a lay hospital, founded by a noblewoman, and run by lay brothers and sisters, although the community still adhered generally to the rule of St. Augustine.

The Abbey of Rievaulx in Yorkshire and the hospital of St Mary Spital, London, both well-excavated and researched institutions, offer the opportunity to look more closely at the similarities between large urban hospitals and monastic infirmaries. The Abbey of Rievaulx, located in the countryside thirty-seven kilometers to the north of York, was founded in 1132 by Walter Espec, a wealthy local aristocrat. This Cistercian foundation was notable for its prominence in the landscape of medieval England, eventually counting eighteen daughter abbeys that spanned the breadth of the country. Cistercian monasteries, as most monastic houses did, followed a claustral plan. This means that its buildings were constructed around one or more cloisters, creating enclosed areas suitable for a religious community that emphasized isolation from the outside world. At Rievaulx, the infirmary had its own claustral complex, a smaller version of the great cloister the bordered the church. The infirmary hall where the sick were housed was a long, aisled building, separated into compartments with wooden screens containing a total of around fifteen beds. A small chapel, constructed in 1200, was present to the west of the hall. In comparison, the hospital complex of St Mary Spital in London, founded in 1197 by a group of wealthy

52 Peter Fergusson and Stuart A. Harrison, *Rievaulx Abbey: Community, Architecture, Memory* (New Haven, CT: Yale University Press, 1999), 43.
merchants, had around 90 beds at its height in the later thirteenth century.\textsuperscript{54} Immediately, there is a serious difference of scale. St Mary’s housed well over ten times as many patients as the infirmary at Rievaulx. The hospital not only offered care to the poor and sick of the city, it also acted as a house for elderly priests, orphans, widows, pregnant women, and even wealthy citizens; in short, it was a foundation aimed at population of far greater scale and complexity than the monastic community of Rievaulx Abbey.\textsuperscript{55} Despite these differences, the physical layout of the hospital was similar in part to the abbey. The infirmary hall, open-aisled as at Rievaulx, was closely connected to a church or chapel. After a renovation in 1235, the sixty-meter long infirmary hall separated the inmates by gender into two sections with a central chapel. Clearly, the inmate’s access to prayer space was crucial for both of these foundations. Even in the last stages of construction at St Mary’s, when the infirmary was moved out of the church, the two spaces were bordering each other.\textsuperscript{56} Not only was St Mary’s infirmary host to many more inmates, but it also only loosely followed a claustral design. The section of the complex belonging to the canons was enclosed, but the infirmary to the east of this area, open to the street and easily accessed. A monastic isolation was simply not possible at a large urban foundation, and the placement of the infirmary reflects this.\textsuperscript{57} Larger hospitals and monastic infirmaries followed similar architectural designs but were built for different

\textsuperscript{54} Bed counts do not instantly reflect the number of inmates. Two, sometimes three people fit in each bed in medieval hospitals, while in monastic infirmaries each bed usually only had one occupant: Connell, \textit{A Bioarchaeological Study of Medieval Burials on the Site of St Mary Spital}, 1.

\textsuperscript{55} Ibid., 194–95.

\textsuperscript{56} Ibid., 195–98.

\textsuperscript{57} See Appendix 1, Plan 3 and Plan 4.
populations. The duties of urban hospitals meant that the rigidity of a monastic spatial layout was neither possible nor necessary.

No hospital of this period was completely secular, even if it was founded by a patron outside the clergy, such as an aristocrat or wealthy merchant. There was an understanding that poverty and illness were both symbolic of the sufferings of Christ, and that illness in particular was thus not purely physical but tied to moral purity. “Medieval medicine and Christianity rely on a model of imbalanced or unholy bodies that foster illnesses, balanced and holy bodies that foster health and virtue.” And many hospitals were directly founded by ecclesiastical authorities, who, for centuries, had been providers of poverty relief and medical care in the Christian community. As Orme and Webster note, “bishops had acquired a responsibility towards the poor at an early date, and they and other Church interests such as monasteries took a prominent role as hospital founders. All but the smallest hospitals came to have chapels – buildings which were under episcopal jurisdiction – and many houses were staffed and headed by clergy.” Even if the house was not founded by a bishop or other church official, there would have been religious facilities on the property, and the physical layout of many hospitals emphasized this. The main infirmary hall was combined with a chapel in many foundations, allowing inmates to participate in religious services even while in bed. The hotel-Dieu in Soissons was founded jointly in 1210 by Selon Claude Dormay, the dean of the cathedral chapter, as well as a local

59 Nicholas Orme and Margaret Webster, *The English Hospital 1070-1570* (New Haven: Yale University Press, 1995), 32.
knight, Guillame de Moustiers. King Louis VIII also donated 60 livres in 1225. Its infirmary hall was not combined with the chapel, as some were, but it was connected to the chapel, enabling easy access for the inmates.\textsuperscript{60} The influence of the church was not only visible through the design of hospital spaces, but also in more direct means. It promoted “the adoption of official hospital statutes incorporating prescriptions set forth by the Church Councils of Paris (1212) and Rouen (1214) and above all by the Fourth Lateran Council (1215)” which prescribed “vows to be taken by those oblates who gave themselves to the task of caring for the sick and the poor. As a result, it became increasingly common for such tasks to be confided to established orders, congregations, and fraternities. Thus the spiritual life of hospital communities was generally governed by the rule of St. Augustine.”\textsuperscript{61} Common use of rule of St. Augustine among hospital communities meant that there were considerable similarities between different hospitals, even between those foundations that were founded by secular persons and by ecclesiastical authorities. Hospitals generally followed this rule, only one of many in medieval Europe, for it was well-suited to those foundations whose inmates had constant interactions with laypeople, and were not expected to abide by strict monastic codes.\textsuperscript{62} For example, at Tonnerre, the brothers and sisters who ran the hospital were lay persons, but lay persons who had taken vows of poverty, chastity, and obedience.\textsuperscript{63} There were many other hospital foundations with similar situations, especially in urban areas where there was a

\textsuperscript{61} Mollat, \textit{The poor in the Middle Ages}, 151.
\textsuperscript{62} Rubin, \textit{Charity and Community in Medieval Cambridge}, 155.
\textsuperscript{63} Courtenay, “The Hospital of Notre-Dame Des Fontenilles at Tonnerre: Medicine as Misericordia,” 79.
greater concentration of wealth and poverty. “The ecclesiastical authorities, which had tolerated the patronage of churches, allowed hospital rectors to be nominated by their founders . . . hospital administrators, some of them laymen, swore an oath to the [city] councils upon assuming office.”  

As Mollat notes, there was no clear division between secular and religious control of hospital foundations. They were not seen in the same light as other religious foundations, for example in contrast to the situation of “monasteries and friaries where, by the thirteenth century, the authorities – especially bishops – were becoming more resistant to the spread of new religious orders and taking steps to control them.”  

Hospitals, on the other hand, were much easier to endow, both due to fewer restrictions and because they could be quite small, with only a few inmates, making them an affordable form of charitable endowment.

Due to the relative lack of capital required to endow a hospital, they proliferated in cities where individual merchants, guilds, and confraternities could afford to endow their own hospital foundation. These lay patrons were understood to have the right to “appoint or approve the warden, lodge in the house on visits and nominate inmates to be maintained there. In turn, the right of patronage descended to the founder’s families or to other lay bodies such as municipal authorities and guilds.”  

Even though the house would have been governed by some variation of the Rule of St. Augustine, the ultimate authority would reside with the patron, and in the case of secular foundations, this meant that they were far more removed from church authority than other major religious institutions. As Rubin notes, “by the fourteenth

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64 Mollat, *The poor in the Middle Ages*, 153.
65 Orme and Webster, *The English Hospital 1070-1570*, 37.
66 Ibid., 34.
century, hospitals and almshouses were conceived as existing in the secular sphere under the supervision of secular bodies such as the town or college.” Of course, many hospitals were church-founded and church-run – the great hospital in Paris was attached to the cathedral – and would have followed routines similar to monastic houses. In England, Henry VIII’s dissolution of the monasteries in 1536-41 resulted in the closure of numerous hospitals, especially the larger, wealthier foundations, which were more likely to follow a monastic rule. One such larger monastic hospital was St. Thomas the Martyr in Southwark. Here, “the brothers . . . were enjoined to conform to the rule of St. Augustine, in which they were professed; they were to study the scriptures, the chant, grammar, and the observance of the rule . . . in contrast the sisters, who were also professed to the Augustinian rule, were ordered to supervise the sick paupers daily and visit them personally.” Interestingly, there was a clear division of labor at this hospital. The sisters were in charge of the physical well-being of the inhabitants, a relationship that was understood even by those outside the governance of the institution, as “a donation made in 1379 for drink for the paupers and the sick in the hospital was to be distributed by the sisters to whom the care of the sick poor was assigned.” In a hospital like St. Thomas the Martyr, the greater wealth enabled the foundation to care for more inhabitants than many of the smaller, secularly founded institutions, but it also would result in its dissolution in 1540 under Henry VIII. The most important division, however, between a hospital founded and run by the church and one founded by a lay patron was that the founding

67 Rubin, Charity and Community in Medieval Cambridge, 147.
69 Ibid.
charter was linked to specific, personal desires of the patron, and in this charter “the special provisions included by patrons form a critical variant [from church foundations] and are an important source for individual agendas, the economic resources of the institution, and the nature of medical care.” All aspects of a hospital’s foundation, from its physical layout to its targeted audience can be seen as a reflection of the patron’s understanding of their relationship to the less fortunate classes of society.

The hospitals of later medieval Europe were, in a general sense, combinations of the monastic infirmary and lodges for paupers and pilgrims. Tracing the evolution of the word hospital, Orme and Webster note that it derives from the Latin hospes, meaning guest. This word evolved into hospitium and then hospitale by 730, known as spital in English by 1176. The actual word hospital did not occur in English until about 1300. Other important terms are maison dieu and almshouse. The medieval hospital was a place for not just the sick but for those who were simply impoverished, destitute, or suffering from old age. They were religious institutions, not because they were always administered by the church but, as the name maison dieu indicates, they were understood to be religious spaces by virtue of their function within society. Because sickness and poverty were such foundational concepts within Christianity, and because bodily health was understood to be tightly connected to spiritual well-being, hospitals operated as spaces that provided both physical and spiritual benefits to their inmates. As Geremek notes, “a hospital was primarily, then, a hospice, and

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70 Courtenay, “The Hospital of Notre-Dame Des Fontenilles at Tonnerre: Medicine as Misericordia,” 79.
71 Orme and Webster, The English Hospital 1070-1570, 39.
the sick were by no means the only clients, or even privileged ones. Even in the more modern definition of the role of a hospital . . . we find a multiplicity of functions: to feed and care for the sick, to maintain beggars, to nurture children and young people, to watch over the insane, and to bring up the blind.” 72 These functions were many, and the number different groups of people that were understood to be the concern of hospitals in medieval society meant that only the very largest and wealthiest hospitals could afford to treat and house all comers. And large and wealthy was, in fact, only applicable to a very small number of hospital foundations in medieval Europe.

A clear majority of hospitals were small and often specialized in just one sector of the population. There might be foundations for orphans, for the blind, for widows, for elderly priests, for pilgrims, for lepers, or for the sick poor in general. One of the more unique foundations was the leper hospital, for their inhabitants were considered impure, necessitating some type of exclusion from society. Leprosy as a disease was not well defined, however. It “was one of the Middle Ages' catch-all terms like 'scrofula' and 'putrid fever', covering a multitude of conditions,” but all of which rendered those suffering from it physically marked. 73 Those who were judged to have leprosy, a proceeding that was as much religious and moral as medical – a common view was that leprosy was caused by venereal infection – were often forced to live in special, segregated hospital. But, “medical assumptions about the alleged infectiousness of leprosy had little impact upon popular responses to the disease until

72 Geremek, The Margins of Society in Late Medieval Paris, 170. The use of modern here should be understood to indicate an early modern view of the hospital, but many larger hospitals were, by the thirteenth century in the case of St Leonard’s in York, caring for orphans, widows, and elderly priests, in addition to the general population of ‘sick poor.’
73 Jeffrey Richards, Sex, Dissidence and Damnation: Minority Groups in the Middle Ages (London ; New York: Routledge, 1990), 150.
at least the late thirteenth century.” Rawcliffe had been stigmatized since biblical times, but it was an exclusion based on ritual pollution rather than a clear understanding of the medical benefits of disease containment. “Leprosi were certainly not excluded from the Christian community, or initially prevented from entering towns to purchase food, visit healing shrines and beg for sustenance.” While lepers were often housed in these segregated houses, it is not the case that they were totally excluded from the social and religious community of the time. Their obvious physical affliction resulted in two competing views, one which held that they were being punished for their moral sins, and another view that, as had been discussed already, identified physical suffering and illness with holiness. Their physical suffering and closely identified them with Christ. As Rawcliffe notes above, lepers were segregated but not banished or completely excluded. They were “allowed to collect alms in public and to live by themselves just past the town walls or near major roads,” occupying “a special but widely accepted niche in society.” Leper houses were located outside the city along the major thoroughfares, placed at important crossroads that enabled the inhabitants to effectively beg for alms. This predilection for begging and alms-gathering was noted by contemporaries, and “when literary writers featured hospital inmates, they showed them as insistent collectors of alms.” While lepers may have been diseased, they were not prevented from interacting with the healthy. Leper hospitals were, interestingly, a foundation more closely associated with disease than most. Even after the turn of the 16th century, the Savoy hospital in London was

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74 Rawcliffe, *Urban Bodies*, 323.
75 Ibid.
76 Risse, *Mending Bodies, Saving Souls*, 177.
77 Orme and Webster, *The English Hospital 1070-1570*, 42, 45.
not restricting its patient population solely to those who were ill. The statutes of this hospital “required that applicants be screened by four or five members of the staff of the hospital . . . of the 100 poor men to be admitted each night the staff were to give preference to sick persons.” As was illustrated in Chapter 1, the combination of poverty and illness served to strengthen the suitability for charitable care, but even those paupers who were not sick were still eligible for entry. The major hospital in Paris was known to “offer a roof to all unfortunates, homeless old people, the infirm and those unfit for work. All sorts of healthy poor lived there on the same terms as the sick.” A hospital like this one, or like St. Leonard’s in York, would have offered places to hundreds of inmates each night, suffering from all sorts of afflictions, including those who were seen as deserving of community support without having any connection to illness. The unfortunates could include not only just the poor, but more specifically, poor widows, poor priests, and orphans. While most hospitals were far smaller than these two foundations, there was seldom a clear division in hospital statutes and rules for admittance between those who were ill and those who were infirm, disabled, or simply looking for a roof over their heads, food, and rest.

The tension over hospital admission was not simply a question of specialization. Hospitals that might have been expected to welcome the ill could prove surprisingly reluctant to admit them, and financial concerns could warp the original goal of the institution. In one such case, “the statutes of the hospital of St. John, Bridgewater, drawn up in 1219 by Bishop Joscelin of Bath and Wells . . .

78 Carlin, “Medieval English Hospitals,” 27.
79 Geremek, The Margins of Society in Late Medieval Paris, 178.
enjoined that the poor, infirm, and needy persons in the infirmary be ministered to by one of the hospital’s brothers and cared for day and night.” This apparent message of inclusivity was not so clear-cut. The statutes went on to specify that “no lepers, lunatics, or persons having the falling sickness or other contagious disease, and no pregnant women, or suckling infants, and no intolerable persons, even though they be poor and infirm, are to be admitted to the house.” Clearly, there was significant leeway given to whomever was in charge of admittance on any given day. It is surprising that there was a hostile attitude to admitting those who were ill, but the ban on intolerable persons is perhaps more understandable. This seems to have been an attempt to weed out those who were not seen as deserving of charity, despite their physical condition. Only the deserving poor and infirm were desired by the patron of the hospital. In hospitals and almshouses, “the resident inmates were expected to engage in some form of intercessory activity for the benefit of their founders and benefactors, their good estate while living and the salvation of their souls after death, a task for which the worthy poor were especially suited.” Admittance of a poor person was a calculated maneuver, for the pauper would be expected to pray for the soul of the patron who was providing food and housing. As Courtenay argues, “in exchange for fiscal endowment, these private charities [hospitals] offered considerable soteriological benefits to their founders and provided an important institutional outlet for personal piety, familial commemoration and architectural

There was an understanding that the inhabitants of the hospital were both working for the salvation of the founder, but also for the founder’s earthly fame and recognition. The bishop who stipulated that only those poor and infirm who were tolerable would be admitted is not nonsensical in this situation, for these persons would literally be representing him as symbols of his charity and virtue. Even those who were not foundational patrons donated with the understanding that the inhabitants would be representing them, as “Ela, countess of Warwick (d. ante 1303) left bequests to the hospital of St. Mary without Bishopsgate, London, that included perpetual annual payments for the poor in the hospital of £1 for milk, £1 for sheets, and £1 for firewood.” Like a donation to a church or monastery to ensure that

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82 Courtenay, “The Hospital of Notre-Dame Des Fontenilles at Tonnerre: Medicine as Misericordia,” 79.
83 Carlin, “Medieval English Hospitals,” 31. What do these monetary amounts mean? Calculating the relative value of currency is a complicated process, for numerous social and economic factors must be considered. [https://www.measuringworth.com/](https://www.measuringworth.com/) is a site run by a group of economists which provides a relative value calculator and a comprehensive explanation of their processes. Taking the donations of Ella of Warwick as an example, her combined total of £3 translated into its current value brings up a

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*Figure 4: Book of donor’s names from the hospital of St Mary Magdalene, Gaywood.*
masses would be said for one’s soul, this bequest emphasizes the focus on comfort over medical care that defined medieval hospitals. The poor whom she is keeping warm and fed are working for her spiritual benefit.

This reciprocal relationship between patron and pauper was not perfect. The hospital’s ability to provide continual care was based on the continual donations of wealthy members of the community, or a solid, profitable endowment. Many of the smaller hospital foundations were not long-lived, for smaller endowments meant a greater reliance on uncertain and inconsistent sources of income, such as alms from begging. Carlin notes that “most leper houses had become redundant by the mid-fifteenth century, and many, particularly the small and poorly endowed, also had become derelict by that time. The leper hospital at Sherburn, for example, which had been founded for a master, three priests, and sixty-five lepers, had become impoverished by 1429. It was reconstituted in 1434 for a master, four chaplains, four clerks, two boy choristers, two lepers if so many could be found, and thirteen poor brothers.”

Leper hospitals were in part a different case, for as leprosy became less common, there was less need for their specific type of care. But like many other hospital foundations, they often suffered from poor endowments as well. Even larger number of options. Since we are talking about food, the commodity category seems appropriate. The first number is the real price of that commodity: £2,141.00. This is a basic calculation of the cost of a generic bundle of commodities, adjusted for inflation. However, this does not take into account the evolving makeup of this bundle of commodities over time (for instance, we would probably not be satisfied with the average possessions of an average 14th century English citizen). The second number is the labour value of that commodity: £42,450.00. This is tied to the average daily wages earned by a person in 1300 their average earnings. Essentially, this number is higher because it reflects how large £3 would feel for someone making an average wage. The third number is the income value of that commodity: £112,500.00. This is the relative wage you would have to be making around 1300 in order to be able to afford something worth £3. As this is based on GDP, which only has been recorded since 1820, this number may not be the most accurate. Clearly, a £3 donation per year was not a small amount.

Ibid., 23.
hospitals were at risk of getting into financial difficulties. The hospital of St Leonard’s in York, which was “intended in 1364 to care for 206 poor in its large dormitory, and to maintain orphans in a hall below, fell victim to the cupidity of its masters, who excluded the poor in favor of those who could pay large sums for places.” And in London, at the large “hospital of St Mary without Bishopsgate, as episcopal visitor found in 1303 that legacies intended for the sick poor were not being paid, that the poor were stinted of their allowances of food and drink, and that the lamps that formerly had hung among the infirm ‘for their solace’ had been removed.” The problems that beset St. Leonard’s were not uncommon. Even in leper houses, some people suffering from the disease were refused admittance due to a lack of institutional funds. “By the late 1400s, few true lepers were left in prominent British, French, and German institutions; the surviving individuals were mostly chronically ill or aged inmates who had made substantial donations to gain admission.” Institutions had always been places that housed large numbers of the infirm. Many catered specifically to elderly groups like widows and priests, but when financial difficulties beset houses it was not uncommon for them to sell places to those who could afford them.

85 Ibid., 34–35. 206 people would not have been a constant number – the populations of these foundations were often in flux.
86 Ibid., 35.
87 Risse, Mending Bodies, Saving Souls, 184.
Chapter 3: The Medieval City

To understand the roles hospitals played in the world of medieval England, and the reasons behind everything from their physical layout to their religious significance it is necessary to understand how medieval cities understood themselves. Hospitals were predominately urban foundations, and as their numbers grew they became significant actors in urban religious and civic life. In the centuries after 1000 cities were becoming increasingly important nodes of commerce, population, and political power. Finding reliable population numbers in this period is difficult, but what is clear is that “England in 1300 was still overwhelmingly rural, with 80 per cent of the population living in villages and hamlets and earning their living from the land.” Cities did not have near to an equal share of England’s population; but, many were large enough to support dozens of hospital foundations, numerous religious houses, and large market spaces that consolidated their social, religious, and economic importance to the surrounding regions. As vast majority of the population was still rural, however, hospitals were not ubiquitous features of medieval life despite their prominence in or near to urban areas. “Towns created their own sick, poor and homeless, and pious town dwellers responded with establishments which

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88 There was a distinct growth in urban centers around the turn of the millennium, to pick a very general date. This was due to a combination of factors, such as increasing agricultural production, and coincided with a growth in trade. The expanding economic connections between the continent and England, especially after the Norman conquest, would be one of the most important forces behind the growth of York.

met their own religious aspirations while serving welfare requirements.”

Urban poverty was just that; an urban creation and not necessarily representative of poor populations in rural areas. Of course, there was considerable interaction between these urban centers and the rural areas surrounding them, and migration was a key factor in bolstering urban populations and increasing economic prosperity. “The leading towns of medieval England served as episcopal seats, contained hospitals and schools . . . hosted regular sessions of the county court and occasional sessions of parliament . . . all towns, large and small, acted as marketing centers for their immediate rural hinterland, which [typically] extended to a radius of about six miles.”

As Laughton notes, important networks of power in medieval England were centered in urban areas, both because they were often centers of religious importance, but also because they had legal and parliamentary influence. The conception of the city as a center is important. Cities derived a significant portion of their importance through their spatial relationships within their wider geographic landscape, functioning as a space of power within the medieval world. “The city of late medieval northern Europe was a spatial being – not just a creation in space but a creation of space. The city was understood and understood itself to be an incursion

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91 Laughton, Life in a Late Medieval City, 3.

92 It is important to note here that while cities were increasing their influence in the political sphere during these centuries, most power still lay in the hands of the rural aristocracy. Urban power was still in a nascent phase. “Monarchs found it convenient to grant rights of municipal autonomy, while making it clear that they would revoke those rights if a city was not governed satisfactorily, or if law and order broke down.” D. M Palliser, Medieval York 600-1540 (Oxford: Oxford University Press, 2014), 136.
upon an existing sociopolitical landscape, a world of different values and practices.”

This argument is vital for it notes that the city was not only a physical space in the medieval world but a symbolic one, a space that reflected specific understandings of how a city should function in relation to other spaces in the medieval landscape. A city cannot simply be understood as a population center, as a series of numbers and physical constructions. The spaces in the city, and the city as a space, were important because of their symbolic significance, in addition to whatever physical properties they possessed.

The city was a space rich with symbolic importance in medieval Europe. It was a community of people, spatially defined, functioning as a small world within the larger medieval landscape.

“In the Middle Ages everything in the Christian world had its rightful place in a divinely ordained and ordered hierarchy that extended through the cosmic ‘body’ above, the macrocosm, to the human body below, the microcosm. The city too was understood to be part of this hierarchy. It came to be seen both as a microcosm of the universe and a macrocosm of ‘man’, an urban ‘body’ placed between the macro and microcosm.”

This understanding of the urban body came to the medieval world though a translation of and a commentary on Plato’s *Timeaus* by Calcidius, a fourth century Christian philosopher whose work was in high circulation through the end of the fifteenth century. Over seventy manuscripts of his translation and commentary survive from the eleventh and twelfth centuries alone, underscoring the ubiquity of a text that emphasizes the religious significance inherent in the spatial orientation of the

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medieval city. Urban space is a representation of both the Christian universe and the human body. The city was seen as a unique space within the medieval Christian worldview, with connections to Jerusalem, the holy city, and enduring symbolic power in many influential early Christian texts. Just as the Christian world was understood to exist as a result of a deliberate design by God, the city, a micro-world, was also seen through this lens. Order was important for it ensured that each person was in his or her proper place within the ‘body’ of the city. The city, according to

Figure 5: Illumination of the Heavenly Jerusalem. While this is not a typical circular arrangement, it emphasizes the city’s gates and symmetrical arrangement.
Calcidius, was “a macrocosm of the human being; all ordered and functioning according to the same principles and overall design, which in the city are present in its spatial form as well as in its social order.” The physical space of the city was directly tied to the understanding of the city as a symbolic body. As the body of the human being was made in the image of God, thus the city, as a ‘body’ itself, was necessarily connected to this divinely inspired creation. Calcidius was not the only medieval scholar to view the city as a cosmic body. Alain de Lille, an influential twelfth-century theologian, also understood that the city was a symbolic representation of the human body, and vice-versa. In his *Pliant of Nature*, he argues that “in the heart, as in the middle of the earthly city, Magnanimity has taken up her abode . . . the loins like the city’s outskirts, give the lower portions of the body willful desires; they do not dare oppose the orders of Magnanimity but obey her will.” Here the moral implications of a sustained city-body metaphor become apparent. The city, like the human body, has regions that de Lille considers centers of moral righteousness. The center of the body and the center of the city are the sources of morality, in conflict with those sections at the periphery. Through this connection with a divinely ordered cosmos, each part of the city takes on a real religious significance, and sets it apart from the spaces outside the bounds of the urban landscape. “The circular-shaped city was itself the innermost of a series of hierarchically arranged concentric rings that organized the whole of the Christian world spatially and geometrically from its center, Jerusalem.” While no cities truly

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95 Ibid., 8.  
96 Ibid., 10. This is from a later work on cosmology by Alan of Lille, his *Pliant of Nature*.  
97 Ibid., 16.
matched this ideal geometric and spatial perfection, each city in Christian medieval Europe was understood to have a connection to this divine city, and its divine order. This understanding of the ideal city came to medieval Europe from the work *De Civitate Dei* by St Augustine. In this work, he conjures up a narrative that places the earth-bound city as a less-than-perfect reflection of the heavenly city. The ultimate goal for man is to ascend from this imperfect city to the perfection of the heavenly Jerusalem. Inhabitants of this perfect city “toiled obediently together for the benefit of all,” and earthly cities thus must strive to imitate this divine organization. The need for cities to work towards this divine perfection was a constant concern for Medieval authorities. England’s King Henry VII (1485-1509) notes that an ideal community must remove “vacabunde rioturs or vngodly disposed personnes” from their towns, for every piece of the community must be working towards the example of divine order and perfection. People and places that were seen to threaten this order were suspect. As Alain de Lille argued, those places at the periphery were suspect because they were outside or nearly outside the bounds of the city. A wall often physically defined the medieval city, acting as a defensive measure not only against physical threats, but more existential ones as well. In a major commercial center of medieval Europe, the city of Ghent, these spatial considerations were clearly present. “Industry – and its social risks – were banned to the outskirts of the city and to the city quarters in the periphery… the peripheral urban quarters were without exception always poor, not to say marginal.” As Alain de Lille argued, those areas

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99 Ibid.
peripheral to the city were morally suspect, for they were farther away from the
‘heart’ of the divinely ordered urban world. The areas and activities considered
detrimental to the moral well-being of the urban body were located farther away from
the central areas of the city. However, there was an understanding that these areas
were still part of the urban body. Many poorer quarters would still have been located
inside the city walls, a symbol of urban power and the boundary between the city and
the countryside.101 And many hospitals, especially those founded for lepers, were
located outside city walls yet were still understood to constitute an important part of
the urban body. While walls demarcated urban space from the surrounding
countryside, they did not create an impenetrable division. “People, commercial goods,
raw materials, livestock, equipment, and money constantly flowed from the
countryside to city and back again.”102 The routes along which goods and people
flowed in and out of the city were vital to the continued wealth of cities, and attracted
clusters of buildings designed to profit off and control those who moved along these
avenues. Urban spaces were rich in symbolic importance, and numerous spaces
within in the city possessed significant power in defining the civic community.

101 Walls are complicated. There is no question that they were symbolically important, but like many
symbols the reality did not conform perfectly to the ideal. The inhabitants of cities did not cluster
inside the walled cities – in York, there would have been open space inside the walls throughout the
medieval period. People spread into the suburbs on their own volition. Furthermore, walls were not
perfect enclosures. They were amalgamations of old and new constructions (York’s medieval walls
included large portions of the Roman ones) and were home to houses and habitations. “Describing the
capture of Waterford by the Normans in 1170, Giraldus Cambrensis reported a house jutting out over
the wall, held up by a beam, which the Normans cut to breach the wall.” David Nicholas, The Growth
of the Medieval City: From Late Antiquity to the Early Fourteenth Century, History of Urban Society
in Europe (London ; New York: Longman, 1997), 93. This is not to say that it is incorrect to think of
walls as having significant spiritual and symbolic importance. But the physical reality was different.
102 Martha C. Howell, “The Spaces of Late Medieval Urbanity,” in Shaping Urban Identity in Late
Medieval Europe, Studies in Urban Social, Economic and Political History of the Medieval and Early
It is difficult to come to a complete understanding of the ways in which urban communities interacted through manipulation of spatial power. In addition to the understanding of the city as a symbolic Christian body, actors - such as large monasteries, the city council, and the ecclesiastical authorities - in the urban community vied for greater control of the civic environment through legal distinctions that manifested themselves in physical demarcations of space. A significant factor in the construction of urban identity was the possession of an urban charter. Charters helped the monarchy to control powerful regional aristocrats and ecclesiastics by enabling them to ally themselves with an emerging mercantile class.

“It was through having a charter issued or ratified by a monarch that the urban body politic gained its legal legitimacy to rule over and govern the lives of urban inhabitants… these [charters] enshrined a process of political incorporation, legally instituting a town or city as a corporate entity, a unifying and ruling ‘body’ with its own economic and judicial privileges and rights.”

Just as religious arguments gave the city a legitimate form, in the construction the city as a religious body, charters granted the city real political power. The possession of legal jurisdiction over a group of citizens was an important source of power and distinction for civic governments, and there was a constant struggle to increase the scope of their legal powers. Another important aspect to civic laws is the way in which they reflected the social organization of medieval cities and the spatial understanding based on moral and spiritual considerations. They “marked out hierarchical social differences and boundaries among inhabitants in ways that reflected this moral topography, making the earthly city a living imitation of the

103 Lilley, *City and Cosmos*, 143.
cosmic ‘city’… these bodily orderings of townspeople were a means by which
marginal social identities were reflected and reinforced… to maintain social order and
difference in the urban body as a whole.”

For instance, buildings that were seen as
threat to the moral purity of the civic community, leper hospitals being a prime
example, were legally required to be placed in certain areas, areas that were in accord
with an understanding of a moral urban topography. While leper hospitals will be
discussed in more detail later, it is important to recognize that legal and moral
topographies manifested themselves in concrete physical spaces in urban geographies.

The charter of a town or city was, in England, held by the consent of the
monarch. Of course, because of the benefits of receiving increased legal autonomy,
urban communities campaigned vigorously to acquire these documents. This process
was closely tied to the increasing wealth of urban centers after the year 1000, for as
“English towns flourished, their leading citizens demanded, and often acquired,
privileges of self-government from the Crown, taking advantage of the king’s need
for money or political support.” In general, towns and cities benefited from the
magna carta of 1215 in which were “confirmed the liberties and free customs of his
[King John’s] cities, boroughs, and towns.” Although King John eventually revoked
this document, the long minority following his death empowered towns and cities
seeking self-government. These charters gave urban communities important legal
powers, but their struggle to claim legal jurisdiction was not only with the crown.
“Cities aggressively mapped the territory within which their laws held sway and the

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104 Ibid., 144.
105 Palliser, Medieval York 600-1540, 132.
legal jurisdiction prevailed thus claiming juridical “space” just as they claimed geographic space.”\footnote{Howell, “The Spaces of Late Medieval Urbanity,” 5.} These struggles over legal and geographic space illustrate yet another way in which the medieval city can be understood in terms of its spatial components. The inhabitants of medieval cities were in a constant struggle for legal and spatial jurisdiction with the various religious liberties present in the major English cities during this period. Secular and religious spaces in the city were distinct yet at the same time constantly in flux. The religious and secular authorities had conflicting areas of legal power, as for example in York, where “both the archbishop and the abbot of St Mary’s were exercising their rights to their own courts, coroners, and gallows; and the city’s jurors testified to the friction that separate jurisdictions produced.”\footnote{Palliser, \textit{Medieval York 600-1540}, 139.} In addition to legal rights, the archbishop and the cathedral chapter were the two largest landholders in the area after the king.\footnote{Ibid., 147.} This is crucial to understanding why there were real, violent conflicts between citizens and these powerful religious institutions, and will be more fully examined in Chapter 5. Large religious foundations that held legal authority were spatially part of the urban environment but not under the control of the city’s government. To understand the urban hospital, it is necessary to keep both of these kinds of special divisions in mind, the moral and the legal.

Hospitals were defined by both of these conceptions of urban space. The largest hospital foundations were often significant religious foundations, and thus, like St Leonard’s hospital in York, were players in the struggle over legal jurisdiction
and spatial control in the city. And in a general sense, although this does not apply by
any means to all hospital foundations, they were “situated at the periphery of urban
settlement,” placed near roads, bridges, ports, and gates, all routes through which
people moved in and out of town. Inside the towns, hospitals were “early foundations,
such as St. Leonard’s, York (dates to the tenth century), or were marginalized to the
poorer or depopulated parishes.” \(^{109}\) The periphery of the urban world was a space rich
with symbolic significance, where the urban space, in both a moral and legal sense,
ended. Placed in this space, hospitals were constructions that marked the beginning
and end of the city, markers recognizable to travelers as symbols of the medieval city.
“Hundreds of hospitals had been established in England by 1300, the overwhelming
majority of them in towns. Hospitals were primarily religious institutions, and, like
frayries, reflected urban status.” \(^{110}\) Hospitals were recognized as important civic
constructions, a way for a city to assert its importance in medieval society. The word
religious is tricky in this sense, for it does not mean that they were controlled by
religious authorities. Some were, of course, but many were endowed by aristocrats,
merchants, or guilds. Thus, by placing them at the entrance to the city, these buildings
could serve as markers of urban power and wealth. Of course, the edges of the cities
were important not just for their visual prominence but for their moral symbolism.
The medieval city was “spatially defined by the leper hospitals and hospitals at its
gates . . . these rings of churches and hospitals . . . served as appropriate markers for
the liminal point where travelers, strangers, and pilgrims left or approached town.” \(^{111}\)

\(^{110}\) Laughton, \textit{Life in a Late Medieval City}, 73.
\(^{111}\) Gilchrist, “Christian Bodies and Souls,” 115.
Hospitals on the margins of the city were located in spaces seen as morally suspect in the understanding of the city as a Christian body, but also functioned as barriers between the limits of the city and the surrounding countryside, protectors of the urban environment. And as hospitals were always imbued with religious significance in the medieval Europe, even foundations targeting marginalized groups would have been understood as standing apart from the moral suspicion surrounding the limits of the city. The poor and sick were both embraced and repulsed in the medieval society, and the foundations that housed and cared for them contained the same conflicting sensibilities.

*Figure 6: Medieval map of Bristol. The prominence of the gates and central cross resemble images of the Heavenly Jerusalem.*
The great number and variety of medieval hospitals prevents an easy analysis of their function and symbolism in medieval society. For this reason, and because hospitals were closely connected to the urban medieval environment, an investigation of the hospitals of a single medieval city offers the possibility of a better understanding of how these foundations functioned and why they developed as they did. York is a city that possessed not only a large number of a hospital foundations, many of which have been subject to significant historical and archaeological investigation, but also occupied a position of importance in medieval England.112 Its politics, religion, economy, and geography are well-documented and can provide vital contextual information for an investigation of hospital foundations.

York was founded by the Romans in the first century of the common era, and continued to be a very prominent urban settlement in the north of England until the end of the middle ages. Its geographic location was a major factor in its transformation into a leading city in medieval England. There are two major reasons for this. It lies on the fastest land route between southern England and Scotland, and the numerous military conflicts between the two countries meant that it evolved into an important military and political center. English monarchs moved their courts to the city throughout the middle ages, seeking better control during periods of warfare with Scotland. In addition to its military and political significance, the city was “situated on a major river system which allowed it to grow into a major trade center in the region, and connected it to a series of rivers and canals that enabled travel by water

112 See Appendix 1, Map 1, and Appendix 2, Table 1.
from York all the way south to Cambridge.\footnote{Palliser, \textit{Medieval York 600-1540}, 4–6.} York’s position as hub for trade in the region meant that it enjoyed a high level of economic prosperity until roughly the fifteenth century. Its economic prosperity is one of the major reasons why it lends itself to an investigation of medieval hospitals. Like other religious foundations, the presence of numerous hospital foundations in a city was the result of a populace that had reached a level of prosperity sufficient to endow the foundations. “Between 1100 and 1300 York shared in a general western European growth in the number, size, and wealth of towns. English towns benefitted especially from the closer trading links fostered with the Continental possessions of the Norman and Angevin kings.”\footnote{Ibid., 296.} As Palliser notes, not only York was enjoying a growth in prosperity and importance during the middle ages. It is a city that mirrors many others in England during this period. York’s relationship with hospital foundations cannot be looked at in isolation, and the trends that its hospitals followed are generally the same for comparable cities across medieval England. Like many other cities, York flourished as the cloth trade grew, and trade routes were established between British Isles and the rest of the Europe.\footnote{St Leonard’s Hospital and Rievaulx Abbey were both invested in the cloth trade, raising sheep for wool on their manors. Urban merchants were not the only group that profited from these trade links. In regards to Rievaulx, “when the Crown confiscated on year’s clip as the Order’s contribution towards the ransom of Richard I in 1193, wool was described as ‘the chief part of their [the Cistercians’] substance.’” Fergusson, \textit{Rievaulx Abbey}, 42.} In the case of York, this period of prosperity began to come to an end in the fifteenth century. England entered a period of economic downturn, clothmaking declined and moved away from the urban centers, and London took a greater share of the continental trade. Londoners’ increasing domination over the English merchant companies severely damaged York’s economy, resulting in population loss and
decreased importance.¹¹⁶ While the economic fluctuation of York is not the focus of this thesis, it is a necessary backdrop to understanding the city’s relationship with its hospitals and impoverished inhabitants. Hospitals were greatly affected by economic hardship, as they (especially the smaller institutions) depended on constant financial support from citizens.

These citizens were a varied group about whom much must be conjectured, for no detailed population statistics survive from before the sixteenth century. Tax records make note of households, not individuals, and household would have varied considerably in size by wealth and social status, making precise numerical calculation impossible. Furthermore, those inhabitants of the city too impoverished to make it

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onto tax records means the very populations that serve as the focus for this thesis are the least visible in the historic record. Some generalizations can be made, however.

“A period of rapid expansion began early in the fourteenth century when York was the seat of the Court and a base for armies, continued in the 1330s and 1340s when the city was the home of a group of great wool merchants, and was prolonged until the end of the century when it became the seat of an export cloth industry.” Poll-tax returns from 1377 provide a population estimate of 13,500 inhabitants, a figure that places York among the largest urban centers in England during the fourteenth century.

Interestingly, the growth of York’s population continued through the years of the Black Death in the mid-to-late fourteenth century. Despite what must have been a devastating number of deaths, the city was attractive to migrants coming from the countryside. There are many reasons people migrated to towns, from working as servants to entering one of the craft professions, work that was simply not available in the countryside. The draw of employment opportunities was enough to make up for population losses sustained during periods of plague and disease. And the epidemics certainly affected the city. The civic government erected numerous plague houses in the city to deal the great numbers of sick and diseased. These shelters could be seen as a simplistic type of hospital themselves, although they were understood to be temporary constructions, kept in readiness until an epidemic hit. With a sizable

118 Gareth Dean, Medieval York (Stroud: Tempus, 2008), 158; Palliser, Medieval York 600-1540, 221.
population and a large influx of wealth from cloth-making and trade for well over a century, York could support a large number of hospitals during the middle ages. The fact that so many hospitals were founded and maintained also suggests that there were a considerable number of impoverished persons within the city, the intended targets of these foundations.

The poor who lived in York did not, for the most part, appear on any sort of official record of the city. And when they began to appear on tax records, it was only those poor who were just rich enough to be able to afford housing within the city. Those who were beggars and vagrants, the jobless and the homeless, are essentially invisible in the historical record. Assuredly, some of these people would have been clients of the hospitals established in the city, or beneficiaries of the frequent distribution of food and drink by churches and monasteries. But it is not possible to reconstruct their numbers, where they lived in York, or much about who they were. There is more information, however, for those who were at the lowest visible rung on the social ladder. York had a number of suburban areas, that is, outside the walls of the city, which tended to develop “along the principal approach routes to the city and were characterized by wider streets used for livestock markets and parking for carts queuing to pay tolls at the gates on market days.”120 These neighborhoods were “usually home to some of the poorest elements of society that made up a large part of the urban population,” those who were the most impoverished or marginalized. There is good reason to believe that this is where many of these invisible poor would have

120 Dean, *Medieval York*, 42.
lived. In general, these suburban areas, as well as a number of parishes on the edges of the walled city, were those places where the poorest members of York’s society lived. Relegated to locations away from the heart of the civic government and wealthy mercantile areas, “the houses of the poor left no trace either in surviving fabrics or in inventories . . . the smallest houses recorded in the inventories were usually those of the poorer clergy.” The distribution of these poor parishes is clearly visible in the tax records from the later middle ages. “The 1524 subsidy return shows a core of six parishes which paid an average of over 40s. (£2) an acre, and adjoining them ten others paying over 10s.; between them, they covered most of the city center. Flanking them, however, were parishes paying 10s. or less, which accounted for most of the parishes just inside and outside the walls.” The city’s wealth was concentrated in the center, and those areas paid more than fourfold what the poor parishes on the outskirts were able to contribute. There may also have been some deliberate political calculation in assessing these areas for less than the wealthy center. “Some impoverished outer parishes made no returns [in the poll tax],” a situation which may reflect a realization of the potential political and social costs of placing a heavy financial burden on the poor. It was in these outskirts that many hospitals were located, for two major reasons. This is where the majority of the impoverished lived. “Blossom Street, the main road running from Micklegate Bar, connected the city to the wider road network giving access to London, Scotland, and the west . . . there were two hospitals along Blossom Street: St. Catherine’s, a leper

121 Ibid., 43; Laughton, *Life in a Late Medieval City*, 52.
123 Ibid., 272.
124 Ibid., 223.
hospital, and St. Thomas of Canterbury which provided hospitality to travelers and help to the poor.” These hospitals were located in a poor, suburban area of the city, home to many of the people to whom St Thomas would have offered shelter. Its placement along a major thoroughfare in and out of the city made it highly visible, a marker of its patron’s commitment to charitable activity. The urban geography of York is of great importance for all types of hospital institutions in the city. Because the medieval city was understood to be a divine body and a representation of the ideal heavenly city of Jerusalem, the actual physical layout and composition of the city must be seen as having real symbolic meaning. Hospitals and other religious foundations on the edges of York were demarcations of the city’s conception of itself as a religious community defined by real spatial limits.

The city of York was host not only to a multitude of hospital foundations, but also to a number of significant religious houses. These large and visible representations of urban piety were an important measure of a city’s importance and were understood by citizens to be necessary for the well-being of their community. Maintenance and foundation of religious houses and buildings were not only the project of a few wealthy community members, the church, or the monarchy, although all of these actors were involved in founding and supporting institutions as well. Due to York’s position as a wealthy center of trade, there were a large number of merchant guilds operating in the city. And like other urban centers during the middle ages, confraternities were active players in the foundation and maintenance of such institutions. “There were gilds which maintained plays, bridges, chapels, chantries,

125 Dean, Medieval York, 45.
hospitals, and Maisons Dieu.”\(^{126}\) Guilds often had associate confraternities that, among other duties, would have “looked after the confraternity hospital or Maison Dieu which houses diseased merchants or the sick and infirm widows of their craft.”\(^{127}\) Citizen groups were actively engaged in the religious life of York, and not only in the sense that they attended church. It was understood that these religious institutions were a fundamental part of urban identity. A confraternity might found a maison dieu because contemporary religious teaching identified it as a proper action to take, but there was also a real sense that these institutions were vital to the functioning of the city itself. York was fortunate in this aspect, for its wealth enabled it to play host to numerous prestigious religious institutions. York’s hospitals were a sign of the city’s prominence and its citizens’ engagement in the foundation and upkeep of religious institutions.\(^ {128}\) Another of the most prominent signals of York’s high status “is the foundation of friaries, those new and almost exclusively urban religious orders. York was one of only nine English towns to attract the four main orders; and furthermore all its four houses were among the twenty English friaries where provincial chapters were held.”\(^ {129}\) Not only are friaries a useful method for comparing the prominence of different cities, they were very popular religious institutions in the medieval period. In a collection of probate inventories and wills from the diocese of Yorkshire from the fourteenth and fifteenth centuries, there are twenty-nine out of the approximately one hundred collected that make mention of


\(^{127}\) Ibid.


\(^{129}\) Palliser, Medieval York 600-1540, 129. See Appendix 1, Map 1.
specific charitable donations. Of these twenty-nine, ten specify a monetary donation to the friaries. And these essentially all are recorded in the same formulaic manner, "Paid to the four orders of mendicant friars of York…” followed by a variable amount.\(^{130}\) This donation is the most common single bequest to a religious institution found in these inventories, a sign that the citizens of York were supportive and engaged with these religious foundations. Unfortunately, the friaries were particularly badly hit by the dissolution of the monasteries under King Henry VIII. There are few physical remains of their buildings, and the records that the orders kept were destroyed when they were disbanded.\(^{131}\) As the city’s fortunes declined in the fifteenth century, these institutions were seriously affected, for they relied on constant contributions, especially those which were small enough to lack any serious endowment. “As early as the beginning of the fifteenth century there are complaints about the poverty of churches . . . the problem was aggravated by the declining fortunes of the city and the inflation of the early sixteenth century.”\(^{132}\) As will be seen, this resulted in significant changes in the ways that hospitals functioned in the city, forcing them to change the way they interacted with the populace they were supposedly founded to serve, changes that can be tracked in the physical footprint some of these hospitals left behind.


\(^{131}\) Palliser, *Medieval York 600-1540*, 129.

Chapter 4 – Leprosy in York

And [the priest] comforts [the leper] and strengthens him to endure with the words of Isaiah spoken concerning our Lord Jesus Christ: - “truly He has borne our griefs and carried our sorrows, yet did we esteem Him as a leper smitten of God and afflicted,” [Isa. liii. 4, Vulgate]; let him say also: “If in weakness of body by means of suffering thou art made like unto Christ, thou mayest surely hope that thou wilt rejoice in spirit with God. May the Most high grant this to thee numbering thee among His faithful ones in the book of life. Amen.”133

As this thesis has argued, the Christian creation of a symbolism that connected human suffering with the struggles of the most venerated figures of the Bible meant that care for the sick and indigent was held in high regard in the world of medieval Europe. The above ritual of seclusion is an excellent example of this symbolism, for it speaks of a category the sick who were particularly important, and in consequence particularly visible in both medieval society and the surviving documentary record. From the twelfth through the end of the fourteenth century the leper was perhaps the most consequential and visible target of charitable giving in England. The clear majority of all leper houses were founded during these few centuries; in fact, “leper houses comprised the single largest group of hospitals founded for a particular named purpose during the Middle Ages… approximately one quarter of all Yorkshire hospitals known to have been in existence before 1300 were founded for the care and

protection of lepers.” What lay reasons lay behind lepers’ special status within medieval society? Thousands of hospitals were constructed to care and house them, they were directly associated, as the excerpt from the Office at the Seclusion of a Leper illustrates, with Christ, and yet the disease, in its final stages, is gruesome, causing serious physical deformations. The numerous contradictions and complications surrounding the treatment of leprous individuals place them in a unique position in medieval society, but they are not so different that no comparisons can be made to other marginalized groups. Physical expressions of illness have always occupied a place within the Christian worldview, facilitating the identification of those who are truly undergoing suffering and are thus deserving of charitable aid. With this in mind, it is not surprising that the leper was so visible in literature discussing charitable acts. The veneration of the leprous had, by the twelfth century, become commonplace. Nobles in in England and France were described in almost identical terms caring for lepers, the act of washing and kissing their feet being particularly emphasized. As a leading city in medieval England, York was host to its own group of leper hospitals. Investigating these specific institutions, their

135 See discussion of poverty and illness in Chapter 1
relationship to civic society, and the changes that they underwent as the centuries progressed allows for a more complete understanding of what role the medieval leper played in his or her society.

The actual disease is a large part of the reason that this population is of continuing historical interest. Leprosy, also known as Hansen’s disease, is caused by the bacillus *mycobacterium leprae* and still infects tens of thousands of people each year, mainly in the Indian subcontinent. It is a strange pathogen, for most of the population is immune and only the smallest fraction of those infected will actually develop the most serious physical deformities associated with the disease. And many of those who do develop the characteristic skin lesions and other deformities succumb to other infectious diseases relatively early on.137 Due to these peculiarities, “leprosy’s mortality rate in medieval Europe is now uncertain and likely to remain so.” Estimates of the number of infected range from one in 200 to over five percent of the population.138 Regardless of the actual number, which must have been visible if not incredibly substantial, the disease reached a position of great importance in the world of medieval charitable giving by the twelfth century. Identifying those with leprosy was a process that combined religious and medical expertise. A number of scholars have argued that, because diagnosis was not done just by medical professionals, people identified as lepers in the middle ages were not necessarily those who were afflicted by this specific pathogen. At the advanced stage, a diagnosis would be simple, but at earlier points the disease has much in common with various

137 Ibid., 1–3.
dermatological conditions. However, investigations of leper hospital cemeteries have indicated that many of those interred were, in fact, suffering from the disease. For example, “palaeopathological studies in Scandinavia have indicated that only the most severely disfigured sufferers were segregated. Evidence from these Scandinavian studies also indicates that the diagnosis of leprosy in the medieval period was accurate.” While this is an interesting area of investigation, it is not, ultimately, very productive. There is simply not enough evidence, especially in England, that remains from leper houses to tell for certain whether most those who were thought to be lepers in medieval Europe were, in fact, suffering from Hansen’s disease. Skeletons cannot tell us if a body that shows none of the characteristics of the disease was uninfected or died from some other infection before the disease could progress. It was also a rather unusual epidemic: from the eleventh to the end of the thirteenth century the disease was becoming increasingly prevalent in the population, reflected in the number of leper hospitals founded, the frequency that it is mentioned in literary and legal sources, and osteoarchaeological evidence, “only to be followed by leprosy’s swift disappearance from most of Europe in the later Middle Ages.” The reasons for the decline in the population are still a mystery. Segregation, to the extent that it did occur, “is unlikely to have halted the transmission of the disease. In the early stages of lepromatous leprosy there would be little nerve involvement and skin lesions are rarely noticed… highly infectious individuals would have avoided

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139 Ibid., 176.
141 Michael Farley and Keith Manchester, “The Cemetery of the Leper Hospital of St Margaret, High Wycombe, Buckinghamshire,” Medieval Archaeology Medieval Archaeology 33, no. 1 (2016): 87. The hospital in question was located in High Wycomb, Buckinghamshire
discovery” until long past when they were first a danger. These investigations are ultimately unimportant, although informative, for understanding what role lepers played in medieval society. Regardless of whether leper hospitals played any part in actually combatting the spread of the disease through some sort of segregation, their physical layouts were understood to be appropriate to a population that was at once embraced as part of a Christian society and rejected for their physical deformities and possibility of infection.

A person stricken with leprosy became part of a Christian narrative with biblical origins. In the middle ages, leper houses were also known as lazar houses, for the leper was understood to figure in a contemporary re-interpretation of the famous parable from Luke.

“There was a rich man [Dives] who dressed in purple garments and fine linen and dined sumptuously each day. // And lying at his door was a poor man named Lazarus, covered with sores, // who would gladly have eaten his fill of the scraps that fell from the rich man’s table. Dogs even used to come and lick his sores. // When the poor man died, he was carried away by angels to the bosom of Abraham.”144

This story could apply to any one of the multitude of poor and indigent in medieval society, for it is only one of the many instances where the bible connects earthly poverty to spiritual wealth, and rewards in the afterlife. However, by the twelfth century, Lazarus was understood by medieval society to represent a leper. During this period, “the Lazarus and Dives narrative was widely depicted in ecclesiastical sculptural programs… leprosy’s evolving association with the wretched and maculate

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beggar made the leper a living icon of medieval poverty.” Peyroux’s comparison of the leper to an icon is quite useful for understanding the complicated serious of relationships that the leper maintained with the rest of society. More than any other marginalized group in medieval society, people in advanced stages of leprosy were visibly afflicted and suffering. Their earthly difficulties were symbolic of the suffering that even those destined for paradise were understood to be headed for in purgatory. “Once stricken by the hand of God, these sinners were holy men and women with whom the pious wished to be associated.” The leper was a symbol of what awaited every Christian soul after death, and as

Figure 9: Christ assuring a leper of their common suffering.

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146 Carole Rawcliffe, in *Leprosy in Medieval England*, opposes the use of this term, identifying it with the long-held view that lepers were heavily ostracized from society with an intent to completely segregate them. This is demonstrably not the case, and I am in agreement with Rawcliffe on this point. I consider the word marginal to be more nuanced, however, than signifying total ostracization, and thus still applicable to the situation of lepers in medieval society.
147 Gilchrist, “Christian Bodies and Souls,” 114.
such an icon was understood to possess real religious potency. Charity directed at lepers was popular for they were so viscerally visibly suffering that there could be no doubt that they were to be rewarded in the afterlife. In fact, this level of veneration is interesting for it leads to a loss of individuality. The leper whose feet are washed by the charitable noble is no more than a symbol of suffering, an icon of poverty. This is, however, only one facet of lepers’ position in society. “Lepers occupied a highly charged and profoundly ambiguous position in medieval society,” argues Peyroux, for this generally positive view of the leper as a contemporary Lazarus was complicated by more negative associations. At the same time that leprosy was suffering with divine reward, it was also a punishment. “The medieval leper was stricken as a punishment for sin, and sufferers were expected by society to assume the role of the penitent.” The leper was not simply a figure to be acted upon by those who were giving charity. He or she was under obligation, like many others in religious segregation, to provide services for society. Their prayers had added significance because they were in an earthly purgatory, and thus they were expected to pray for those who gave them support. “Anxious Christians… certainly hoped that God would incline favorably to the commendatory prayers intoned, day after day, on their behalf by the sick.” And lepers were segregated, to some respect, from the rest of society. Canon law prescribed that they be relegated to their own company, with their own churches and cemeteries. To this purpose, lepers were recognizable

members of society not only by their physical deformities by also by their distinctive
dress and accoutrements. “A distinctive, penitential habit was worn, perhaps
accompanied by decalced (barefooted) observances typical of penitential orders,”\textsuperscript{152} and the \textit{Office at the Seclusion of a Leper} specifies that “before he enters his house,
he ought to have… his signal the clappers, a hood and cloak.”\textsuperscript{153} Lepers are
noteworthy because they were associated with clear, well-known symbols. Their
distinctive dress, the begging cup, and the clappers were just as much as part of them
as their disease was. In particular, the clappers would have announced the leper
possibly even before he or she was seen, removing any chance of those identified as
afflicted from moving anonymously in society.

The leper was truly a medieval icon, for he or she was saddled with a
multitude of associations and expectations. Even the physical deformities of the leper
were complicated symbols. The human body was understood to be a holy creation,
laid out in a divine ordained order, where proper order and unity was key.\textsuperscript{154} But
leprosy ravaged the human body, deforming it and even, in later stages, causing the
loss of limbs. The leper’s imperfect body was at the same time venerated and
condemned for its physical suffering. As Rawcliffe argues, the leper can be seen as
both “the butchered corpse of the traitor,” that “reinforced the shame of corporeal
punishment,” and “the saint, whose remains might be scattered in countless
reliquaries.”\textsuperscript{155} These complicated and multi-layered associations with piety and sin
are key to understanding how the leper was treated and interacted with in medieval

\begin{thebibliography}{9}
\bibitem{gilchrist} Gilchrist, “Christian Bodies and Souls,” 114.
\bibitem{clay} Clay, \textit{The Mediaeval Hospitals of England.}, 276.
\bibitem{lilley} Lilley, \textit{City and Cosmos}, 8.
\bibitem{rawcliffe} Rawcliffe, \textit{Leprosy in Medieval England}, 141.
\end{thebibliography}
society. Despite the survival of texts describing rituals for placing the leper into seclusion, it is abundantly clear that the leper was very much an active member of society, albeit one playing roles imposed on him/her by the rest of the community.

Leprosy was a disease most visible in towns and in urban life, for the dense populations, generally poor hygiene, and inadequate diet of the poorer members of the city provided the disease with perfect conditions to spread. And as most leper hospitals in England were founded in or near urban centers, and their upkeep provided for by citizens of the town, the diseased were never that far away. After a leper was diagnosed, they were compelled to remove themselves from the company of the uninfected, to at least some degree. Peyroux argues that they “underwent a change in social status by which those who were officially excised became completely and permanently dependent upon the good will and material beneficence of members of the surrounding society… the foundation and support of lepers’ houses became a focal point of civic participation in the growing urban centers.” Peyroux is correct in noting that the leper houses were focal points of urban collective action, but the leper was not only active in his or her hospital. They were also not entirely dependent on the good will of others in the community, for they had some freedom of movement and were able to continue to participate in civic life. Lepers were not, in fact, so segregated as canon law and ritual texts suggest. Lepers of the hospital of St Mary Magdalen in Southampton were not able to “attend the feasts held by the port’s guild merchant,” and yet they could participate in the festivities, “drinking the ale that

156 There were, of course, a number of leper hospitals in England founded well into the countryside. But even these, such as the hospital at Harbledown, Kent, were situated near well-frequented roads: Rawcliffe, *Leprosy in Medieval England*, 305. See Appendix 1, Map 2.

was set aside for them on these occasions.”⁵⁵⁸ And in Launceston, a town in Cornwall, the inhabitants of the leper house were able to join one of the major religious guilds, thus “sharing in – and no doubt augmenting – the benefits accrued through the prayers, masses, and other intercessory activities of the brethren.”⁵⁵⁹ These were not uncommon occurrences, as numerous other towns and cities across England incorporated lepers into civic life. Lepers were thus understood to be continuing members of the Christian community, even in ways that took them from their designated residences and placed them into non-diseased society.⁶⁰ In the case of the Cornish town, the participation of lepers in the primary religious guild was clearly to the benefit of more than just the leprous. As such powerful symbols of religious suffering, the leper was spiritually powerful, and their prayers were consequently highly valued. In instances like this, “religious duty, spiritual self-interest and political pragmatism were all… intertwined in the medieval civic treatment of lepers.”⁶¹ Nowhere were these series of diverse interactions and associations more visible than in the leper hospital itself. The leper hospital was the center of the civic community’s interaction with its leprous members, and this combination of religious duty and pragmatism is tied up in numerous aspects of the design and location of the houses.

Despite being the most numerous type of foundation targeting a distinct social group in medieval England, leprosaria are not well documented. Part of this is because they also tend to be early foundations, and appear in documentary evidence

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⁵⁵⁹ Ibid.
⁶⁰ Ibid., 325.
only a number of centuries after their original foundation. This makes dating them precisely, or identifying their original patrons, very difficult. In addition, as leprosy faded from the medieval population after the fourteenth century, leper hospitals were often rededicated for other functions, often as almshouses. Well-preserved documentation for leper houses is thus quite rare. Patricia Cullum, in her work on hospitals in medieval Yorkshire, notes that “houses making provision for the poor and sick may disguise an original function providing specifically for lepers.” What is certain is that leper houses were numerous, with hundreds founded in England between the twelfth and fourteenth centuries, the majority of these near cities and towns. Urban centers were focal points of leper hospital foundations, and they were an important symbol of urban importance during the middle ages. York had five leper hospitals, but even small towns often had at least one. Rawcliffe notes that “whereas over 50 percent of the boroughs established in Yorkshire before 1200 boasted at least one leper house, none of the townships which failed to achieve borough status made such a conspicuous investment.” Civic communities recognized that leper houses were conspicuous displays of wealth and power, one of the symbols of an important regional center. These foundations were important symbols even though they were normally quite small. An apostolic community was an idealized arrangement for leper houses, housing twelve as well as a master, even if many leper hospitals would rarely have hosted exactly this number of inmates. The

162 Ibid., 20.
163 These were: St Nicholas (which is discussed in detail during this chapter), St Helen, St Katherine, St Mary Magdalene, and Monkbridge/ St Leonard. (Hospitals and Charitable Provision, 34-36)
164 Rawcliffe, Urban Bodies, 331.
165 Rubin, Charity and Community in Medieval Cambridge, 115.
small size of most of these foundations, a trait shared with hospitals in general, suggests that the actual number of people suffering from advanced stages of the disease may not have been extreme.

After 1300 many of these foundations ran into problems trying to fill their beds with actual sufferers from the disease. Leper hospitals were not only a symbol of political power, but there was real religious impetus to create a semi-segregated and regulated community. The medieval city was a human body writ large, an imitation of the perfection of the Heavenly Jerusalem. Order was key, and it applied not only to the physical properties of the city but to its populace as well. Lepers were, while beneficial religious icons, also dangers to an idealized community. Leper hospitals fulfilled a need to place this population in ritual segregation from the rest of the city, to control a spiritually powerful but also spiritually dangerous population. In the heyday of leprosaria foundations, beginning in the twelfth century, most institutions were endowed by monarchs as well as the higher nobility of church and state, and later by a newly wealthy urban merchant class and civic communities. All leper houses were religious institutions to an extent, whether or not they were founded by ecclesiastical authorities. They “could never be fully professed religious, but they often assumed penitential discipline, were separated by sex, donned a habit and observed some canonical routine.” This religious character was vital for the effectiveness of the leper hospital, and its acceptance by the community of which it was a part. The Office at the seclusion of a leper states clearly that the leper is

166 Lilley, City and Cosmos, 131–33.
167 Rawcliffe, Urban Bodies, 328.
168 Rubin, Charity and Community in Medieval Cambridge, 114.
expected to faithfully recite prayers for the Christian community, which is one of the most important reasons why donors were interested in endowing leper houses. The prayers of the religious were thought to shorten one’s stay in purgatory – numerous souls in Dante’s *Purgatorio* specifically ask him to intercede for them in his prayers when he returns to the world of the living. Leper houses run by monastic institutions were the most likely to follow a monastic rule, usually that of St Augustine, but these were the exception rather than the rule. Monastic supervision of a community of lepers may have been suitable, for both communities were similarly situated. Lepers, like monks, were separated from the rest of society to a varying degree and were expected to use their greater religious capital to benefit others. “There was a strong sense of implicit contract by which the religious protected the city by their example, preaching, and prayer, and received alimentation in exchange.”

In comparison to the few larger institutions, the majority of leper hospitals were small and in flux, often rededicated and placed under the oversight of new authorities. This was a process that generally took place later in the history of many of these foundations, as civic communities gained wealth and power. “By the later thirteenth century the mayor and commonalty of York were electing the nominee for the mastership of St Nicholas,” one of the most well-documented leper houses in the city. Management of a leper house conferred substantial benefits on the patron, but it also was a way to ensure that the hospital was functioning properly. Citizens and institutions in cities were

involved in the upkeep of leper houses even if they did not actually control the house. In fourteenth-century York, the large hospital of St Leonard’s, not a leper hospital itself, supplied food and drink to all the leper houses surrounding the city.\footnote{Ibid., 30. See Appendix 1, Map 1, and Appendix 2, Table 1.} Moving briefly to the continent, the leper house of Mont-aux-Malades in Rouen follows this common path of leper houses. It was formally founded in the twelfth century due to the support of “high-status lay and ecclesiastical patrons, above all members of the Anglo-Norman royal family,” performing charitable actions towards lepers that underlined “not only their piety and concern for their future salvation, but also their sense of responsibility for the needy, and political skill in publicly demonstrating these attributes.”\footnote{Brenner, \textit{Leprosy and Charity in Medieval Rouen}, 19, 24.} By the thirteenth century aristocratic patronage had waned and prominent burgesses in the city took over management of the hospital. This was generally representative of the path many leper hospitals took, as early aristocratic or ecclesiastical patronage was replaced by civic communities who had an interest in making sure their leper houses would continue to function properly. But, as leprosy declined in the population, or houses entered financial difficulties, leprosaria often diverged from their original intended mission. A closer look at a specific leper house, St Nicholas in York, and the urban community in which it existed will focus specially on these types of challenges and changes. It is first necessary, however, to look more closely at the buildings and locations of the foundations themselves.

Leper houses were very rarely located inside city walls. Even so, most these hospitals were founded hardly any serious distance from the city near gates, bridges,
markets, and major roads. While Lilley argues that cities expelled and marked those who were seen as societal deviants, placing them into places like the suburbs, which “were seen as the most suitable place for such perceived deviants, reflecting and reinforcing the idea that the outsider in society was always at the physical margins, placed away from… the city’s head,” this does not apply perfectly to lepers.\footnote{Lilley, City and Cosmos, 153–54.} They could accurately be depicted as deviants, proscribed by law to be removed from urban centers, and their houses were placed in marginal, suburban, and poor areas of the city, but at the same time they were hardly segregated. In a city, the hospitals were located at places where large numbers of people came and went, visibly dominating crossroads and important bridges. In the city of Norwich “the five leperhouses were situated on five out of the six main roads out of the city (the sixth had another hospital and an anchorhold within the walls).”\footnote{Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547,” 35; Rawcliffe, Leprosy in Medieval England, 312. See Appendix 1, Map 2.} Leper houses may have been prohibited from being established in the city proper, but they greeted travelers arriving at cities all over Europe. The hospital of Mont-aux-Malades in Rouen was placed on the main road from Rouen to Dieppe, visibly announcing the approach to the city and proclaiming the patronage of its founders and supporters.\footnote{Brenner, Leprosy and Charity in Medieval Rouen, 21.} The suburban location of such institutions cannot truly be understood as real segregation from the civic community, for, regardless of community participation in the hospitals, these hospitals visually defined the medieval city. They were easily one of the most visible signs of a large city in the middle ages. However, sites in suburban areas were also well-suited to a leper house. The approaches and outskirts of the city can be
understood as a powerful liminal space, where people moved in and out of a uniquely conceived community. “The siting of leper hospitals was intended to increase the visibility of lepers,” while also serving to display the charity of the founders to a wide audience and to create a boundary for the town, one both physical and spiritual. 177

These transitory spaces were representative of the medieval leper, and vice versa, for the leper was symbolically situated between life and death. The Office at the Seclusion of a Leper describes how “the priest… casts earth on each of [the leper’s] feet, saying: “Be thou dead to the world, but alive again unto God.” 178 While this text should be looked at critically, for it narrates a ritual of seclusion suggesting segregation far stricter than what lepers would have actually experienced, this phrase is very useful for understanding the unique position lepers occupied in the community, and why their hospitals were located in suburban spaces. Leper hospitals were located in areas that were similarly boundary spaces. These hospitals served numerous functions for both lepers and non-infected townspeople, as people harnessed their spiritual capital for personal and community benefits. Many individuals who were not lepers frequented leper hospital chapels, and in one case, at St Leonard’s hospital, Northampton: “its chapel served from the outset as a parish church, where local people worshipped alongside the patients.” 179 Clearly, the narrative of segregation and isolation that the Office illustrates breaks down in this instance. Leper hospitals were not just landmarks but religious destinations for members of the community where they could benefit from the powerful religious

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179 Rawcliffe, Urban Bodies, 324–25.
associations of the leper inmates. And their proximity to roads offered travelers an opportunity to offer prayers for a safe journey.\textsuperscript{180} This is only one aspect of the ways these hospitals worked for the well-being of urban populations. Leper hospitals, arrayed around the periphery of cities in medieval England, also operated as spiritual markers for the civic community.

Walls were not the only defense that urban communities erected against outside threats to their community. Religious institutions, like hospitals and churches, and even smaller constructions such as boundary crosses, created a spiritual defense, or boundary, for the city. “Extramural leprosaria often pre-dated the erection of boundary crosses, such as that constructed in marble by the burgesses of Lynn during the plague year of 1361.”\textsuperscript{181} Extramural threats to the city could be deterred by the creation of a series of these religious spaces. As spaces housing members of the community who carried such powerful religious connotations, leper houses operated as powerful boundary symbols for cities. They worked as protective landmarks, and were incorporated into city rituals. “As late as the fifteenth century citizens of York used leper hospitals, as well as crosses, to mark the processional circuit that conferred divine protection upon those who lived within the walls.”\textsuperscript{182} Leper hospitals were incorporated into York’s civic community, working towards its spiritual protection

\textsuperscript{180} Rawcliffe, \textit{Leprosy in Medieval England}, 308.
\textsuperscript{181} Rawcliffe, \textit{Urban Bodies}, 324.
\textsuperscript{182} Ibid.; Rawcliffe, \textit{Leprosy in Medieval England}, 309. The processional circuit in York was as follows: “by a ditch and a marsh next to the spitalwell by way next the abbot of St Mary’s… as far as the Maudeleyn spetell in the highway which leads from York to Clyfton… as far as the cross next the bridge beyond the mill of St Nicholas’s hospital… next to the close of the hospital of St Nicholas aforesaid.” [Quoted in Rawcliffe \textit{Life in the Medieval Leper House} from the York Memorandum Book (Surtees Society, clxxxvi, 1973] The use of leper hospitals to define town boundaries can also be seen in Ipswich, where “From the bull stake on the Cornhill in the said burgh of Yepiswiche unto the close of the [leper] hospital of Seynt Leonard” \textit{VCH Suffolk II}, p. 139.
and well-being. Their location in the suburban, transitory space outside the walls of York may have been, in part, to remove them from the healthy population of the city, but it was a ritualized segregation. The hospitals’ incorporation into city rituals concerned with the spiritual health of the community indicates that lepers were not actually segregated, nor intended to be. They occupied a liminal space on the outside of the city, where their contradictory symbolism was able to work towards the benefit of a community which they were still very much a part of.

A traveler arriving in York from the east during the early thirteenth century would have passed by the leper hospital of St Nicholas before arriving the gates of the city. We can only conjecture what the structure would have looked like, for there are no remaining physical traces of the building. From documentary sources, it is apparent that the hospital, unlike the other leper houses in York, possessed large grants of land. The hospital received its foundational grant from the abbot of St Mary’s abbey, the large Benedictine monastery outside the west of the city. Abbot Savary, holding office from 1132-61 “gave 12 acres of land, a dwelling and yard, a carucate of land near the Foss and 2 acres for a vegetable garden; this gift was confirmed by Abbot Clement (1161-84).” Clearly, some of this land was intended for the lepers to work themselves, but it is also possible that it provided income for the institution. The grant of land was not the norm for leper houses, and the other four

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hospitals that York eventually acquired were, as far as is known, without comparable land assets. For St Nicholas, this enabled the hospital to reach a level of wealth that may have enabled the institution to operate relatively self-sufficiently. Leper hospitals were often short on funds, for, unlike monastic foundations, they did not have the income necessary to feed their inmates and maintain their buildings. Like any independent religious institution, *leprosaria* “needed land, as well as a regular supply of water for laundry, waste disposal, brewing, cooking, gardening, animal husbandry, and the creation of fishponds,” but for the most part leper hospitals were small, poorly-endowed foundations.\(^\text{184}\) Possessing at least some of these assets, St Nicholas was well-off for the early part of its existence. Of course, smaller and less wealthy leper institutions were not without any possibility of raising funds. In addition to the religious and symbolic importance of leper houses’ placement in the suburbs of York, all of the city’s leper hospitals were placed on major roads, intersections, near to bridges, gates, and marketplaces. This enabled the inmates of these hospitals to solicit alms from passing travelers and townspeople, and this source of income was absolutely critical for the poorer houses. It was thus financially necessary for a leper house to be located in places where they could control the flow of people. The leper’s traditional garb underscores not only the importance attached to their ability to solicit alms but the fact that this was understood to be a fundamental duty or role the leper had in medieval society. A leper carried clappers, to announce his or her presence, and a begging cup. “The situation of the typical lepers’ hostel… facilitated the collection of donations from passers-by in alms-boxes attached to the side of the

\(^{184}\) Rawcliffe, *Urban Bodies*, 326.
building even when the leprous themselves were not out collecting.”\(^{185}\) The churches of these leper houses were not only places for the pious to benefit from the spiritual capital of the lepers, for they were also places in which the traveler or townsperson gave back to the lepers by donating alms. This transactional relationship was not understood to in any way sully the leper’s spiritual power, at least before the disease began to fade away from the population. Because of the necessity of procuring alms, leper houses can be identified by grants of “royal licenses to beg or archiepiscopal indulgences to those giving alms,” and these are “often the first, sometimes the only, indication of the existence of a leper hospital.”\(^{186}\) Alms were so important to the longevity of leprosaria that a foundation near Lausanne in Switzerland was moved from its original location, one that had been selected for its isolation, to a more populous location, for they were unable to collect a large enough quantity of alms at the former.\(^{187}\) Alms were usually the major source of income for a leper house, although they also received bequests in wills. In a collection of 100 probate inventories from the diocese of York, only four leave money to leper houses. Many of these inventories contain no bequests at all, but even with this in mind this is only four out of the thirty inventories that leave money to charitable causes. Some townspeople were thinking of leper houses, but not a large proportion. Interestingly, when money was left to leper houses, it was always in general – the individual houses were not specified. This is similar to those bequests to the four friaries of the city, and perhaps indicates that leper houses were seen as providing city-wide benefits, no

\(^{185}\) Peyroux, “The Leper’s Kiss,” 175; Rawcliffe, *Urban Bodies*, 327.
matter where in the suburbs they were located. Some bequests were recorded, but even this collection of probate inventories is only from the late fourteenth century onwards. Wills from earlier centuries do not survive as well, leaving gaps in our knowledge in the period when leper foundations were at their height. And the specific value of alms that houses received are even less visible. They would not have been recorded, and thus are missing completely from the historical record. It “leaves little trace in the records of even the greatest and most bureaucratically developed of medieval institutions, and none at all in such small institutions where internal documents are quite non-existent.” This is unfortunate, for alms were, without a doubt, one of the most important factors taken into account when selecting a location for a leper hospital. In York, as in many other cities in medieval England, the leper hospitals each commanded one approach the city. This nameless traveler arriving in York would have been hard-pressed to make his way into the city without passing by one of the city’s leprosaria.

Like many leper hospitals, St Nicholas would have appeared quite differently to those visiting it in different centuries. Leper houses often grew organically, as lepers had formed their own semi-isolated communities sometimes before any permanent, endowed structure had been constructed for them. “It is generally assumed that leper houses developed organically with no predetermined plan, and consisted of cells or cottages built of timber and thatch.” This would not always have been the case, as it is unlikely that each of the leper hospitals around York were

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188 Stell and York Archaeological Trust, *Probate Inventories of the York Diocese, 1350-1500*.  
190 See image of Norwich  
191 Gilchrist, “Christian Bodies and Souls,” 104.
home to a community of lepers before their formation, and most of the time it is simply not possible to tell. These early communities would have been unlikely to leave any trace on the historical record. However, in the case of the leper hospital of Mont-aux-Malades in Rouen, a group of leprous individuals living outside of the town predated the official foundation.\footnote{Brenner, *Leprosy and Charity in Medieval Rouen*, 19.} One aspect of these unofficial communities may have carried over into the official foundations, as the individual cottages or cells of an unorganized community became a normal configuration for official endowed foundations. The Office suggests that these cottage colonies of the leprous were common configurations. It states that the leper’s “house ought to be small, with a well, a couch furnished with coverlets, a pillow, a chest, a table, a seat… and other needful articles.”\footnote{Clay, *The Mediaeval Hospitals of England*, 276.} This fits the narrative of isolation that was certainly a part of the arrangement of leper houses, although it was always more of an isolation in name rather than in practice. Even in those communities which were organized as colonies of houses, the lepers would have spent much of the day collecting alms and interacting with those outside of the hospital. And it was the norm that these communities also possessed a chapel where the lepers could worship as a community and welcome others.

As an unusually wealthy foundation, St Nicholas offers an example of an exception to this arrangement for its inmates. It was a substantial construction, boasting, in the twelfth century, a substantial aisled hall divided at one end “into cubicles and hearths,” with dimensions “at least twenty meters long and ten wide.”\footnote{Dean, *Medieval York*, 103; Rawcliffe, *Leprosy in Medieval England*, 332. See Appendix 1, Plan 2.}
It seems likely that St Nicholas resembled those hospitals and monastic infirmaries with open floor plans, were the inmates lived in common. This was possibly not that uncommon of an arrangement at this early date, for in Ilford a leper hospital there was also using a common dormitory. By the thirteenth century, however, “common halls were partitioned into separate cells, as recorded for St. Nicholas, York.”

St Nicholas may have modified its arrangements to match the majority of the newer foundations that usually followed the cottage organization, but this layout also may have offered benefits to the inhabitants. And as the number of people with the disease decreased, these large, open halls were simply too large for the few lepers they housed. In the twelfth century, St Nicholas may have housed as many as thirty-forty lepers, but at the last recorded mention of the hospital in the fifteenth century, there were eight inmates. Individual spaces better suited a smaller population.

Unfortunately, this downsizing coincided with a decline of the hospital in general. “A damning inquiry of 1291 into abuses at St Nicholas’s hospital, York, found that the practice of admitting lepers and ‘the old and feeble of the city’ without charge had been abandoned by the master in favour of entry fees up to £15 payable by all newcomers.” Entry fees must have helped support a hospital in financial difficulties as fewer alms were being brought in. But it came at the cost of diminished religious credibility, for even those who were not actually suffering from leprosy gained entrance, as did those who were not under obligation to offer prayers for the community. This alarmed citizens of York, as masses which had been said for the

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197 Rawcliffe, Urban Bodies, 320.
benefit of their and their relatives’ souls were slowed or stopped entirely.\textsuperscript{198} The hospital had ceased to hold up its end of the bargain, providing religious benefits to the city in exchange for financial support from wills and almsgiving. And this would have affected its ability, based on the spiritual power of its leprous inhabitants, to function as a locus of power for the city as part of its spiritual boundary. This prompted the civic government of York to take over the hospital, as by the end of the same century the “mayor and commonalty of York were electing the nominee for the mastership of St Nicholas.”\textsuperscript{199} The rules regarding the collection of alms was adjusted to try and help the financial situation of the hospital, as the box which kept the alms from those visiting the church was more tightly secured. It “was only to be opened before all; if they could not agree as to the disposal of the alms in it, then such alms were to be used for the hospital.”\textsuperscript{200} But even before this rule was put into place, the hospital had been accepting people who were not lepers for financial benefit. The master Richard de Derfeld, near the end of the thirteenth century, “admitted Robert Bartrem of Wilberfoss into the hospital without the consent of the brethren and sisters. He received 23 marks for this, but as the jurors understood did not use it for the common service of the hospital. He received a leper \textit{pro Deo}, and another by consent of the brethren and sisters for 23 marks, spent on the needs of the hospital.”\textsuperscript{201} He was not the first master of the hospital to require entrance fees for some inhabitants, but was the first to be accused of using these funds for his own

\textsuperscript{198} Ibid., 330.
\textsuperscript{199} Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547,” 27.
\textsuperscript{201} Ibid.
personal enrichment. St Nicholas was, in this respect, following a common pattern of many leper houses during this period, where the financial problems of the house forced the community to dilute itself with those who were not, in fact, lepers. St Nicholas was seriously affected by financial problems and difficulties with acquiring actual lepers, enough so that it transitioned away from function as a leper house. “By the late fourteenth century it was taking women who were able to pay the entrance fee, and was probably no longer being regarded as a leperhouse.”

At this point, York still had four other leper houses, so the city was not left without a place for the leprous to live. However, it is clear that despite the spiritual benefits that lepers provided for the community, their hospitals were not always able to survive. A period of financial mismanagement helped push St Nicholas away from its original function, despite its comparatively substantial endowment of land. The path that St Nicholas took was not unique. The leper hospital of St James in Chichester gradually moved away from its origins as a leper hospital, and “the last reference to the inmates as lepers is in a will of 1418. By 1442 six of the eight inmates were married, including the prior, and spent most nights at home with their wives.”

As the history of St Nicholas makes clear, this was not an immediate change. Many leper hospitals would have changed gradually, admitting more and more of the non-leprous until they changed functions altogether, resembling an almshouse rather than a leper hospital. It would have become harder and harder for hospitals to find lepers to admit, and more necessary that they receive some kind of financial benefit for each person.

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203 Lee and Magilton, “The Cemetery of the Hospital of St James and St Mary Magdalene, Chichester - A Case Study,” 274.
204 See Chapter 5, and Appendix 1, Plan 6 and Plan 8.
admitted. This did not mean, however, that lepers ceased to be an important focus of hospital foundations, for many were founded throughout the fourteenth century, after St Nicholas had lost its lepers. Leper hospitals followed a similar pattern as other small hospital institutions and maison dieu, persisting for a few generations before being replaced by newer and more popular foundations. Whatever pattern of change that they followed, leprosaria followed a general pattern in the development of hospitals, adopting a physical layout of private dwelling spaces rather than common halls. Leper hospitals were attractive dwelling spaces, for they allowed a person to benefit from their religious associations while the individual rooms provided some level of privacy and physical comfort. As the number of actual lepers declined, these hospitals must have lost some of the religious associations they embodied. But it is hard to tell just how communal attitudes would have developed. As St Nicholas shows, the urban community was actively involved in the hospital into the fourteenth century, attempting to fix some of its administrative and financial difficulties. Leper houses are still mentioned in the probate inventories into the mid-fifteenth century, when most leper houses would have been struggling to find lepers to admit to their community. In 1472, the bequests of William Gale, a citizen of York, states that the executors “paid to the four leper-houses in the suburbs of York 7s. 8d.”205 By the end fifteenth century, very few leper houses were being founded in England, but the ones that still existed were clearly still seen as beneficial institutions by the citizens of York.206 The idea of the leper persisted as a powerful religious icon even when there

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206 Two other leper houses of York are recorded as functioning well past the end of the fourteenth century. “The hospital of St. Helen, or Fishergate Hospital… stood near the extinct church of St. Helen in Fishergate, and possibly was attached to it. In 1444 Archbishop Kemp granted an indulgence for
must have been many fewer of them actually present in society, and the institutions founded to house them retained some of this religious potency as the disease faded from English communities.

three years to all who contributed towards the reparation of the house or dwelling of the lepers of 'St. Elene,' commonly called 'in Fishergate.' The hospital of St. Katherine… stood outside Micklegate Bar, near the church or chapel of St. James. In 1333 protection for two years was granted by Edward III for the leprous men of the hospital collecting alms. It housed lepers of both sexes, (fn. 266) and as one of the charities of the city escaped suppression.” Page, “Hospitals: York.”
The York leper houses offer examples of foundations created for a small yet incredibly influential population on the margins of medieval society. But lepers were never dominant in terms of population, even when the disease was at its height. The far larger, ill-defined population of those who were living in serious poverty would have interacted with different kinds of hospital foundations. One such kind of hospital (the large, open-ward foundations) has already been discussed in some detail in Chapter 2. St Leonard’s was York’s primary example, and it was, in fact, one of the most substantial hospitals in England. But despite its large size, it is not clear if its importance to charitable action in the city was equal to its great wealth and physical prominence. For there were a multitude of smaller foundations, York’s maisons dieu, which by virtue of their locality and thus greater familiarity may have been nearly as significant.

In medieval York, St Leonard’s lay in the north-west of the city, bordering the city wall and the Minister, York’s cathedral. This foundation offers an opportunity to examine how the sick poor as a larger, generally undifferentiated mass were treated in an urban society. Exploring its relations with the civic community of York enables a better understanding of how the city’s inhabitants related to this hospital and its inmates. St Leonard’s cannot be seen as a perfectly typical medieval hospital, however. It was unusually large, and in the thirteenth and fourteenth centuries when it could boast of having well over 200 inmates “it was possibly the largest hospital in
the country, certainly the largest outside London.” As even St Nicholas would have had no more than forty to sixty inhabitants at its largest size, St Leonard’s dwarfed every other hospital in the city. But its large size means that it both leaves some physical remains, uncommon for a hospital, and was frequently present in the historical record, both which allow for a much more comprehensive analysis of its social and spatial development. And where physical remains are lacking, comparisons to other hospitals of similar size, structure, and function can help to construct a more complete understanding.

Comparisons are necessary for understanding the physical structure of St Leonard’s, for only sections of it survive into the modern day. There has been substantial construction through the center of the hospital complex, leaving only a section of the infirmary hall and of the claustral range behind. The infirmary hall resembles that found at Tonnerre and St Mary Spital, with a long, open-aisled building closely connected to chapels. The remnants of the claustral range are so fragmentary that little can be said about them, except that they do indicate St Leonard’s had a cloister. This is normal for a hospital of this size. Like St Mary Spital, the cloister would have been a traditional part of a more strictly monastic hospital, although the infirmary does not seem to have been directly attached to it.

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208 See Appendix 1, Plan 5.

209 Cullum notes that there appear to have been two chapels attached at odd angles, an unusual arrangement, although the general presence of a chapel is to be expected. This may have been due to the original location of the main church and/or to the lack of space in the compound: Cullum, “St Leonard’s Hospital,” 16.

210 Cullum, “St Leonard’s Hospital, York: The Spatial and Social Analysis of an Augustinian Hospital,” 15–17.
St Leonard’s was one of the oldest hospitals in England. This is not only important for emphasizing its longevity in the urban landscape of York; the fact that it survived for over six centuries indicates that it was built on a solid financial and institutional structure. The hospital staff followed the Rule of St Augustine, like the majority of hospitals during this period, but “the masters of St Leonard's were never subject to the rule, and in the thirteenth century it was envisaged that the master might even be a layman.” Similarly to the lay sisters of the hospital at Tonnerre, while the master might have been a layman, he would have been required to take oaths of poverty and chastity to conform the Rule. The staff at St Leonards in the mid-thirteenth century included both religious and lay brothers, eight sisters, a master, and a number of clerks, cooks, and other lay workers. This rule was suited to hospital foundations as it allowed for greater interaction with laity and more freedom of movement than most other monastic rules permitted. The hospital was, before adopting the Augustinian rule, under the control of the Minister and its brothers secular priests. Around 1137 the hospital burned down and was relocated farther away from the cathedral, becoming more independent in the process. Originally known as St Peter’s hospital, the first buildings were thought to have been constructed during the reign of King Athelstan in 936 for old and infirm priests of the Minister during his campaigns in the north. Sources from this period relating to the hospital are nonexistent, unfortunately, making this foundational story at best a probable conjecture. “The

212 Courtenay, “The Hospital of Notre-Dame Des Fontenilles at Tonnerre: Medicine as Misericordia,” 95.
213 Cullum, “St Leonard’s Hospital, York: The Spatial and Social Analysis of an Augustinian Hospital,” 13–14.
Historia Fundationis of St Leonard's appears to collate a number of sources for the history of the hospital to the Conquest… connecting Athelstan with the north, particularly Beverley, Durham and York. The Historia appears to use the strong traditions of Athelstan's visits to Beverley and Durham to bolster the hospital's claims to him as founder."\(^{215}\) The Historia is a twelfth century document, well removed from the tenth century origins of the hospital. There is not a surviving record of the foundational grants that created St Leonard’s, as they were either lost to time or preserved orally. Why was this foundational story important to the hospital? At question were two major issues. If Athelstan had founded the hospital, it would place it under the authority of the crown, rather than local oversight such as the archbishop, the minister, or the civic government. And the hospital held the right to levy a special tax all across Yorkshire, which would have been legitimized by connecting it to Athelstan. The question of patronage is complicated. It includes issues such as the control of the position of the hospital master and the hospital’s right to a liberty in York, but on a more basic level, securing royal patronage meant that the crown continued give financial support to St Leonard’s. “Henry I… alleviated its burdens by freeing all hospital lands from geld and custom, granting them traditional rights . . . to hold court and judge, to assess and collect tolls, and to summarily judge thieves caught on hospital lands.”\(^{216}\) With the patronage of the crown, St Leonard’s received continued substantial financial support. After the hospital burned in a fire in 1137, the hospital was in need of substantial rebuilding, and its connection with the crown

meant that King Stephen was actively involved in this reconstruction process.\(^{217}\) These royal grants, while enabling the hospital to continue to thrive on solid financial footing, also helped to push towards greater independence from local authorities.

Despite the claim to have been founded by Athelstan, St Leonard’s was a dependent of the Minister until around the time of the donations of King Henry I and Stephen. Gaining independence from the Minister enabled St Leonard’s to grow into one of the most important religious houses in the city.

St Leonard’s financial situation separates it from the majority of hospital foundations in England, and certainly in the city of York. It possessed numerous landholdings across Yorkshire and large areas of property in the city itself, as well as rights to levy certain taxes, a financial structure rather more similar to a monastery than a hospital. The income supposedly granted by Athelstan was a system of thraves, also known as the Petercorn, a concept dating from the Anglo-Saxon period of England. Even if it was not specifically Athelstan himself who granted the right to levy this tax to the hospital, it does indicate that the institution was likely founded before the conquest. “The thrave was a measure of grain, usually twenty-four sheaves or two stooks, and one was taken from every plough ploughing (that is from every ploughland or carucate, about 120 acres) in the diocese of York, later reckoned as the counties of Yorkshire, Westmorland, Cumberland and Lancashire.”\(^{218}\) The income from this tax formed a significant part of the hospital’s annual income. At its peak wealth in the thirteenth century, the hospital drew most of its income from the

\(^{217}\) Ibid.
\(^{218}\) Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547,” 73.
countryside, mainly from rents, manors, and the thraves. While the leper houses of York, and most of the other smaller hospitals in the city, drew their income from alms, bequests in wills, and patronage by the wealthy, St Leonard’s was, to some extent, financially independent, in that its wealth was based on land that it owned, and not dependent on individual or even collective generosity. Its system of land ownership is similar to a monastic system, like at Rievaulx Abbey in north Yorkshire. This Cistercian house, like St Leonard’s, owned numerous estates scattered across the county from which it derived the majority of its income. Of course, the hospital possessed these manors and rights because they had been at one time granted or donated, but by the thirteenth century the hospital was very wealthy. “The total value of St Leonard's in 1287 was £1,262 17s 5d: of this the largest source of income was thraves and other collections which at £460 was over one third of the total income; next came wool, rents and manors, in descending order valued at between £186-250 each; and finally churches providing £104.” The financial independence ensured that St Leonard’s escaped the fate of many of the smaller hospitals in the city, which were prone to financial collapse as they relied heavily on small bequests and alms. The hospital, as the last element in this list suggests, also possessed a number of dependent churches, some of which were actually small hospitals themselves. This started in the previous century, but the inclusion on this financial record suggests it persisted into the thirteenth. St Leonard’s was unique

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219 Rievaulx, Fountains, and Byland were the three largest Cistercian houses in Yorkshire, and three of the largest in all of England. The north was a popular location for Cistercian houses, as they favored deserted and uncultivated land, or at least places isolated from inhabited settlements. In Yorkshire, this led them into sheep raising and wool production. C.H. Lawrence, *Medieval Monasticism*, 148.


among hospitals in England in the early twelfth century for the foundations of dependent hospitals on land it owned outside York. Later, other networks of hospitals, like the Order of St Lazarus, the Hospitallers, and the order of St Anthony of Vienne in France would found numerous connected institutions. These dependencies were significantly smaller hospitals than St Leonard’s itself; for instance, “the property at Hedon which William of Aumale granted to the hospital in 1138 or 1143 allowed not only for its use as a collection point for the thraves, but also for the hospital to settle five poor people there.” This indicates that St Leonard’s was operating quite similarly to a monastery, with a system of dependent houses scattered throughout the countryside which could facilitate the collection of rents and taxes in addition to providing income themselves. However, despite this solid financial base, the hospital found itself in financial difficulties in the fifteenth century. York as a whole was undergoing an economic contraction, and this appears to have affected the rents from the properties it owned in the city, which made up almost a quarter of its income. “Depopulation and economic decline meant that it became increasingly difficult to let properties at the old, or sometimes any, rent, and income from this source started to decline.” But this was not the only financial difficulty the hospital was facing in this period. Even those incomes from rural areas, like the manors and the thraves, were declining, partly because St Leonard’s was having difficulty enforcing collection of these rents and taxes: “in 1416 the hospital claimed that it was losing £160 yearly from detention” of the thraves, despite an increase in

222 Ibid., 82.
223 Ibid., 132.
legal cases brought against those who were refusing to pay.\textsuperscript{224} The loss of income from both urban and rural sources placed the hospital in a precarious financial position, forcing it lower the number of inmates and likely to reduce the amount of food and drink it distributed around the city as well. One of the largest financial blows came in the later fifteenth century, when the unpopularity of the thraves caused a revolt in the East Riding in 1469, culminating in failed march on York. Edward IV responded by cancelling the right to levy the thraves, removing one of the most substantial incomes St Leonard’s possessed.\textsuperscript{225} By the time of the dissolution, the hospital was only able to house around sixty inmates, around one-fourth of the people it had been hosting in the thirteenth century. For an urban foundation, St Leonard’s was tightly connected to the rural areas surrounding York. Its incomes were, while larger and more substantial than most other hospitals, clearly the cause of serious unrest. And in these incomes it is more difficult to see the presence of the personal, voluntary charity that supported York’s leper houses and smaller hospitals. There are only two bequests that mention of St Leonard’s hospital in the collection of probate inventories compiled by P.M. Stell. While these documents only date from after 1350, both mentions of the hospital are from the 1490s, when the hospital would have been substantially diminished from its thirteenth century height. One leaves two shillings to the hospital, while the other is more detailed. The probate inventory of Thomas Symson, a parson, states: “Bequeathed to the hospital of Saint Leonard for the brothers and sisters £1. Each poor man in the same hospital 1d. - total 6s. 8d.”\textsuperscript{226}

\textsuperscript{224} Ibid., 119.
\textsuperscript{225} Ibid., 118–19.
\textsuperscript{226} Stell and York Archaeological Trust, \textit{Probate Inventories of the York Diocese, 1350-1500}, 670–71.
Since there were twelve pennies in shilling, this suggests that at least at the time this will was carried out there were eighty poor men in residence. For one of the largest hospitals in York, it barely features in the record of charitable giving illustrated by this collection of probate inventories. Only two of the twenty-nine that specify some type of charitable action leave anything to the hospital, a possible indication that, despite St Leonard’s prominence in the city, it was not a central focus of individual charity.

It would be inaccurate to claim that St Leonard’s was not an influential hospital in the city, regardless of how much it factored in the daily lives of most of York’s citizens. The duties of the hospital can be generally divided into two categories: caring for the sick, infirm, or elderly in the infirmary, or providing food and drink to paupers to those not actually in residence, often at the gates of the compound. This second duty can be said to include the food and drink provided to those in the city prison and distributed to York’s leper houses. These donations of food and drink were substantial: “in 1293 it distributed weekly at the gate 261 loaves, 247 herrings, thirty-three dishes of meat, and thirteen gallons of ale.”227 The number of people receiving these donations was supposedly around thirty in the thirteenth century, and thus combining this with the donations to the prisoners at York Castle, whose numbers varied but could reach up to 300, and to the leper houses, St Leonard’s was aiding far more people outside its precinct than in.228 The hospital acted as a locus for charitable giving, using its wealthy endowment to support

228 Cullum, “St Leonard’s Hospital, York: The Spatial and Social Analysis of an Augustinian Hospital,” 17–18.
hospitals, like the leper institutions, that were far more dependent on temporary forms of income. The two groups of poor and sick who benefited most directly from St Leonard’s were its inmates and those people who were the recipients of the donations of food and drink at the gate. These groups were specifically mentioned in a series of injunctions issued by a royal chancellor in the fourteenth century, and their ideal populations noted.

“Thirty poor folk… who were called *custumarii* were to have the accustomed alms daily at the hospital gate… in addition there were always to be in the house the customary number of sick poor folk, namely 206, and this number was to be carefully maintained. The sick were not to be dismissed until convalescent and able to work, when others were to take their place. Any who recovered and were allowed to remain were to be set to work, and were not to eat the bread of idleness.”  

The recipients of food distributed at the gate of the hospital were not simply a random gathering of paupers. While some beggars would likely have been present, the thirty people enumerated in the injunctions were those who had purchased what was essentially a living. In a basic sense, this meant that one was paying the hospital to provide for them in their old age or infirmity. This could mean that the person, or persons, were housed in St Leonard’s infirmary, but it often meant that they lived elsewhere, and the hospital provided them with food and drink from its own kitchens. There were two main types offered by St Leonard’s. Liveries were the cheaper option, providing for one person food, drink, and possibly housing. And there were two types of these, cremettal and sacerdotal. The second was aimed at elderly clerics, as its names implies, and was the most common. The first takes its name from the word cremett, another term for a pauper, and were not commonly purchased, instead

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229 Page, “Hospitals: York.”
often being given, perhaps to an elderly servant. It is not clear exactly what these
entailed, for they could be either financial support or donations of food and drink, and
it appears that they occasionally expired, and had to be renewed. Corrodies were
more expensive, for they ensured that an entire household would receive support from
the hospital, for the rest of their lives. It might be accurate to call these an early kind
of retirement plan, for they promised that the purchaser would be well cared for as
they aged and became in need of outside care.\(^{230}\) In the case of corrodies, the
recipients were often those who had deserved of some sort of royal charity, most
often either “minor members of the royal household and others with a long history of
service to the Crown; and poor people who had some claim on royal charity.”
(Hospitals and Charitable Provision, 182) This might mean a widow who lost her
husband in a war or an aging courtier. These essentially created two other classes of
people in the hospital – those who were holders of these incomes, and those sick poor
who were treated and released. Would these inhabitants or dependents of the hospital
have counted towards the 206 sick poor to be housed in the infirmary? The answer is
likely a no. As the injunctions specified, the hospital was not to expel inmates from
the beds before they were fully convalescent.\(^{231}\) Obviously, this would not have
applied to those people who had purchased a living from St Leonard’s, many of
whom may not have even been in residence. And these holders of liveries or
corrodies were likely elderly and possibly infirm, rather than suffering from a
temporary illness. Unfortunately, the sick poor who were housed in the infirmary are
not represented well in the historical record. Those who possessed liveries or

\(^{231}\) Page, “Hospitals: York.”
corrodies were recorded by the hospital, for the were paying for the privilege, but there is no record of the occupants of the free beds given to those who needed them. What is also interesting is that St Leonard’s, unlike a number of other hospitals in York, was actively engaged in treatment of the sick poor who were not chronically ill or infirm. Most hospitals in the city were essentially providers of hospice care, as there was no sense that their inhabitants would be recovering from their old age. Of course, the hospital also cared for the more permanent residents as well, but there does seem to have been a general understanding that for many of its sick residents, recovery was possible. And there would have been a varying population of poor travelers seeking shelter for a limited time, often only for a night. This was a common sight at the larger hospital foundations.232 The liveries and corrodies are some of the most visible ways in which citizens of York interacted on a daily basis with St Leonard’s, even though the volume of those sick poor being treated at the hospital, or those seeking temporary shelter, must have been far greater. They were, however, clearly on the minds of some of York’s citizens. In 1307 Jollan de Nevill funded three beds in St Leonard’s. This was a substantial donation – he gave the hospital a church and a parcel of land – and ensured a number of benefits. Prayers would be said for his soul by both the brothers of the hospital and those poor people who used said beds, and he would likely have been able to grant space in the beds to specific people if he wished, such as an elderly servant. This was an act of charity rather similar to founding a maison dieu or a small hospital, but by using the institutional framework of St Leonard’s with its solid financial base the donor would not have had to worry

about maintaining a hospital themselves.\textsuperscript{233} In comparison to St Nicholas’ hospital,\textsuperscript{234} St Leonard’s was receiving donations that were far more substantial. And because of its financial security, it was not so dependent on the continuous community involvement that supported York’s leper houses, as well as smaller hospitals.

The size of St Leonard’s may actually have adversely affected its relationship with York’s civic community. Like the other large religious houses in York, the hospital possessed the right to numerous legal freedoms. These liberties, which were briefly touched on earlier in this thesis, stemmed mainly from St Leonard’s close association with the crown, but also from ecclesiastical authorities. “Adrian IV provided various ecclesiastical privileges such as immunity from tithes, and excommunication placed upon any who should enter any property of the hospital with violence, or to loot or burgle.”\textsuperscript{235} The hospital had the right to prosecute and try those who committed crimes on its land, as well as assess some tolls, rights which, for instance, the Abbey of St Mary also possessed. As St Leonard’s owned land across the county, this legal power made sense, allowing the hospital to prosecute criminals on its land without needing to rely on other, local authorities. But this was a contentious issue, especially in the city. By holding these rights, the hospital was denying the city council the power to enforce the law on hospital land, much of which was inside York’s boundaries. “The attempt by the city government to claim the patronage in about 1281 was at least in part motivated by a desire to regain, or extend its jurisdiction in areas where the hospital had become sole authority.”\textsuperscript{236} The liberty

\begin{flushleft}
\textsuperscript{233} Ibid., 162.  \\
\textsuperscript{234} See Chapter 4.  \\
\textsuperscript{235} Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547,” 94.  \\
\textsuperscript{236} Ibid., 95.
\end{flushleft}
the hospital held meant that enforcing the law in York could be rather complicated. One who committed a crime in an area under legal control of the civic government but who lived in an area under legal control of St Leonard’s would essentially have to be extradited, for the city possessed no legal jurisdiction over them. As cities and civic governments grew more powerful, these ecclesiastical liberties were targets for destruction, or at least diminishment, for they cut into the town’s legal sovereignty. The competing legal jurisdictions resulted in sometimes comical situations such as a time “when the sheriffs’ sergeants drew blood at one of the Minister gates, and were ordered by the Minister treasurer to do public penance, the city forbade them to comply.”\(^\text{237}\) These episodes of violence directed against the liberties was not uncommon. In 1354, following a number of violent attacks on the abbey of St. Mary’s, the Crown imposed a long-lasting settlement, whose “verdict was more favorable to the citizens, who regained control over the suburb of Bootham, though not Marygate.”\(^\text{238}\) Whole sections of York lived under the direct control of church authorities, and, in a real sense, these liberties were not truly part of the city of York, although geographically they were within the town’s boundaries. In 1381-1382, there were further episodes of violence in York, directed at the major religious institutions, St. Leonard’s included. In late 1382, the “mayor and council were ordered to protect St Leonard’s” by the Crown.\(^\text{239}\) (Medieval York, Palliser, 194) These legal struggles offer an important insight into the hospital’s position in the community of York.

\(^{238}\) Ibid., 153.
\(^{239}\) Ibid. Violence in cities was not only confined to English towns – they were common throughout western Europe as these newly powerful communes asserted their power against the entrenched nobility and clergy.
Citizens directed their anger at St Leonard’s, perhaps because it was known to be wealthy, or was simply a prominent symbol of the city. The hospital received less attention in the collection of probate inventories than the leper hospitals and friaries, even though it was clearly the largest, wealthiest institution of its kind in the north of England. The explanation lies in the ways in which the citizens of York understood their position in the urban community.

While the large, wealthy ecclesiastical institutions stand out today as symbols of York’s prominence as an urban center, and physically would have stood out in the medieval city, they were not so central in the daily lives of its citizens. In York, “the townspeople’s primary loyalties were to their parishes . . . this is clear from the increasing number of surviving wills, showing that citizens nearly always requested burial in their parish churches, which were also the focus of their bequests of furnishings and ornaments, and of requests for endowed prayers.” 240 Their charity was focused locally, not primarily at the large, well-endowed churches or hospitals. For example, “although many citizens left a bequest to [the Minister’s] fabric fund, it was usually a traditional 4d., far less than was often given to parish churches and friaries.” 241 The local focus of those who were not nobles or powerful ecclesiastics was on smaller churches, and smaller hospitals, as they were more immediate and thus a more important part of daily life for an average citizen. St Leonard’s was engaged in distribution of food and drink, but at its gate, to local inhabitants. Its patrons were the wealthy, who could afford to give grants of land, or even those who

240 Most would have been buried in the parish graveyard, making burial in the actual church a high honor.
241 Palliser, Medieval York 600-1540, 280.
did not reside in the city, such as the various monarchs who patronized the institution. A citizen of York was more likely to donate to their local church, and more likely to donate to their local hospital, their local poor. The violence that sometimes erupted against the large religious foundations, including St Leonard’s, illustrates its distance from small, local hospitals. The cathedral chapter of York, which also possessed a liberty like St Leonard’s, was the subject of an inquest in 1276. It was found that the cathedral chapter had extended its control throughout the city and the suburbs, absorbing these new properties into its liberty. St Leonard’s also owned a large number of residential buildings which were not subject to taxation by the city council. These large religious institutions were not recipients of widespread charitable donations of a small, individual scale. They controlled certain areas of the city, from which they received rents and incomes, but those citizens who lived in areas not under their control would likely have had a closer hospital, a more local church, to donate to. “The devotional life of the laity . . . still centered round their parish churches, except on some major festivals.” The larger institutions were certainly important to city life, but are less useful when trying to understand how an urban community dealt with the poor and the sick. Of course, the wealth and prominence of these larger institutions does mean that they are far better recorded, and far better preserved, than smaller churches and hospitals.

The smallest, and most common type of hospital in the city of York were the *maisons dieu*, personal foundations that, because of their minute size and relative

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242 Ibid., 148–52.
243 Ibid., 283.
poverty of endowment leave little to no trace in the historical record. “In York there were at least a dozen, including a civic maison dieu, which is an absolute minimum; the numbers were almost certainly not less than eighteen, as well as five guild hospitals.”²⁴⁴ It is not only hard to find any record of these institutions, but it is also hard to generalize about them, for the often personal nature of their foundation means that they performed functions based on individual preference. While St Leonard’s can be usefully compared to other large hospital institutions, maisons dieu focused on all kinds of people in need of charity, from widows to cripples to the elderly. They might be located in their own buildings, in the basement of guild halls, or in part of the founder’s house. But they are important, just as parish churches are important, for many of them would have been the most local hospital for the average citizen of York. The “alderman Thomas Holme… founded almshouses or maisons dieu, and many others made bequests to them.”²⁴⁵ Some of these almshouses were intended for pious women, probably widows, to live together. Around 1400, there is record of a house of poor widows in St Andrewgate.²⁴⁶ Both are generally later foundations: most of these hospitals were founded in the fourteenth century and onwards. The reasons for the appearance of numerous almshouses and maisons dieu is not clear. Patricia Cullum offers a number of possible explanations for their growth in popularity, from a spike in economic prosperity, to the declining state of other hospitals, including St Leonard’s, in York, to the gradual economic decline of the city in the fifteenth century which may have prompted guilds to found almshouses to care for their poorer

²⁴⁵ Palliser, Medieval York 600-1540, 219.
²⁴⁶ Ibid., 220. See image here
members. There is no real understanding of why they were founded in large numbers. What did separate *maisons dieu* from other hospital foundations was that they were not affiliated with the church. Most, being founded by private citizens, run out of houses or basements, would hardly have been able to maintain more than a few inmates.

Since there is little surviving information about *maisons dieu* in general, especially physical remains, their geographic distribution in York is not well known. Their relatively short existence means that any map of *maisons dieu* is only accurate for a specific section of time. They were even known to move locations. “The fraternity of St. Christopher had a maison dieu [in Fishergate] mentioned in wills in 1430 and 1444 but, in the middle of the fifteenth century, they had their maison dieu near the Gildhall in Coney Street.” Some were founded in people’s houses, like “John de Craven's maisondieu, near Layerthorpe in York,” which “may well have been in his own home, and Agnes Brome of Scarborough (d.1400), built one at the bottom of her garden.” And some were concentrated in particularly poor areas, such as St Andrewgate in York. However, unlike hospitals in general, *maisons dieu* were located in all parts of the city, not mostly on the edges or in the suburbs. These were clearly local hospital institutions, in most cases personal projects of a wealthier citizens. What were the relationships of York’s citizens with these institutions? As many of them were founded in after the fourteenth century, the larger hospitals, like St Leonard’s and St Nicholas’, were in serious decline. While this may have led to an

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increasing number of smaller foundations, to make up for the loss of the larger influences, it seems just as likely that York’s citizens were more engaged on a local charitable level. Parish churches attracted more frequent charitable gifts, and *maisons dieu*, like these small churches, had strong connections to local areas and local citizens. The parish was not simply a neighborhood division, they were the centers of local, daily religious life and community engagement. And they were often very small areas, which led to a re-organization of the York parish boundaries in the thirteenth century, “because of the need to prevent rival claims over rights and fees between the many city churches which had been founded so close together.” Of the twenty-seven wills found that mention St Helen’s, “twenty-one wills asked for burial in the church, one in the churchyard and one in the church or courtyard, and the will of a rector… referred to the tomb of his parents in the church.” This was a very small parish on the edge of the city, one of the poorest in York. But despite this, there was clearly a strong sense of local loyalty. It was traditional that one was buried in the parish cemetery, and these burial fees also provided a crucial source of income for small chapels. Its poverty intensified in the mid-14\textsuperscript{th} century as York entered economic decline. “In the 1420 or 1434 the parish was in the lowest bracket of assessment to royal taxation, being one of a group of seven neighboring parishes which were assessed together for £3, at a time when the rich central parishes were each paying between £10 and £14.” This understandably placed the church into

\[\text{250} \text{ See Appendix 1, Map 3.}\]


\[\text{253} \text{ Magilton, *The Church of St Helen-on-the-Walls, Aldwark*, 8.}\]
financial difficulties, which would contribute to its eventual disappearance. There is record of a *maison dieu* near St Helen’s church, possibly established by the Merchant Taylors’ who had a hall nearby as well, perhaps built to house some of the poor in this impoverished parish. What does seem to be the case is that even those local areas without a hospital, which may have been very poor themselves, participated in charity that may have worked through the parish church. “John Barnyngham (d.1457), Treasurer of York Minster, apparently had fond memories of a former parish as he left 20s to the *‘antiquos pauperes parochianos de Frekehham iuxta Mildehhale’* in the diocese of Norwich, of which he had once been rector.”

While this does not say anything specifically about the city of York, there is no reason to believe this was an unusual donation. The poor targeted in this bequest would have been well-known in the parish. Similarly, those paupers who were living in *maisons dieu* and almshouses would have been well known in their communities, for they were expected, if physically able, to earn some money begging in the surrounding parish. Two wills from York where donations to *maisons dieu* are recorded speak to the normality of begging. “Alice de Bridford of York, widow, (d.1390) left 1d to each infirm pauper in each maisondieu who was not able to beg. Bernard de Everton of York, chaplain, (d.1407) left 6s 8d to the poor in the *domus dei* of Thomas Howom and 4d to each bedridden pauper unable to go out and beg within the parish of St Mary (within which Howom's maisondieu lay), and 2d to each pauper who was able to go out and beg daily from door to door within the parish.”

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255 Ibid., 336.
maison sdieu, and can help give some context to the bequest of John Barnyngham, at least in the sense that one can see how individuals, rather than the poor as a faceless mass, were the beneficiaries of this local charity. The probate inventory of Henry Bowet, an archbishop of York who passed away in 1423, notes that alms were “distributed to the poor on the day of the main obsequies £33 6s. 8d,” and at the year's mind: “distributed to the poor on the same day £8.” This is a significant sum of money, but bequests like this, specifying an amount to be given away at the funeral to the poor were commonplace. Nearly every probate inventory that includes a will mentions a donation at the funeral. As funerals happened at the local parish churches, these events would have been attended by local paupers, from local almshouses or maisons dieu in the area. This method of distributing charity ensured that the donor’s money went to those who he or she might have known as part of the parish community. In a world where one might worry about whether the recipient of one’s charity was deserving, or at least could be trusted to pray for the soul of the donor, donations to and foundations of maisons dieu may have been seen as more valuable than a bequest to a larger, less familiar institution. “Richard Kirketon of York, chaplain, (d.1486), left a garden in Blossomgate to sustain the poor in the maisondieu of John Bedford, gentleman, in Little St Andrewgate on condition that his heirs have the right to present a pauper chosen by them to a bed in the maisondieu.” Like the practice of endowing a bed in St Leonard’s, this donation ensured that the family would be able to benefit from the prayers of a pauper for an extended period of time, without needing to resort to founding a hospital themselves. And it also ensured that

256 Stell and York Archaeological Trust, Probate Inventories of the York Diocese, 1350-1500, 544-45.
they could choose who would benefit from their charity. *Maisons dieu* were local, often personal hospital foundations, which provided for a small number of individuals. But these individuals would be familiar faces in the community, attractive and dependable recipients for charitable donations. Another group of institutions that would likely have benefited from local support would have been the numerous smaller hospitals in York which were loosely based on a monastic community, governed by a master, where the inmates were expected to take vows. Most would have had chapels. Many almshouses followed this form as well, for they often developed from earlier hospital foundations.

The small hospital, or almshouse, of St Mary in the Horsefair was endowed as a home for elderly priests. This was not an uncommon type of foundation. St Leonard’s had in fact been created in part to fulfill this function before it expanded into its larger form. In 1318 the hospital housed “a master, two assistant chaplains and six aged and infirm chaplains.”°²⁵⁸ The presence of a master and chaplains indicates that this was a more substantial hospital than a *maison dieu*, for it would have functioned as a miniature religious community like the one found at St Leonard’s. A *maison dieu* would not have been likely to have any resident staff. In the initial period of the hospital’s existence, there was a large infirmary hall attached to a chapel on the east end of the building, similar to the traditional monastic infirmary design. This underwent significant change in the 15th and 16th centuries, as the hall-and-chapel layout was transformed into more distinct residential areas. It is likely that the

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communal dwelling of the earlier building was abandoned in favor of a quadrangular plan of separate dwellings.\textsuperscript{259} This offers an example of a transition from the open-ward hospital to the almshouse. It is certainly interesting to postulate what might have prompted this change from communal living to individual residences in the later 15\textsuperscript{th} and 16\textsuperscript{th} centuries, but there is no concrete explanation. C.H. Lawrence, in his work on medieval monasticism, notes this change, for it occurred in monastic communities as well. In his opinion, it is tied to a shifting social preference for privacy over communal life. Beginning in the 12\textsuperscript{th} century, new monastic orders came into existence in opposition to the traditional forms of monastic life. “The reaction was… a rejection of a type of community life that imposed a crushing burden of vocal prayer and external ritual and made no concession to the need of the individual for solitude, private prayer, or reflection.”\textsuperscript{260} (C.H. Lawrence, \textit{Western Monasticism}, 126) The difficulty is that this was a 12\textsuperscript{th}-century movement, while hospitals were abandoning communal life much later. It seems odd that the break between these movements would be so large if they were connected. Lawrence makes a compelling argument, however, that this move towards privacy continued to grow through the 14\textsuperscript{th} century, a time when hospitals were also changing. In her article on monastic dormitories, Virginia Jansen notes that during this century more houses were transitioning to enclosed rooms rather than communal spaces, a process widespread enough that in 1335 a papal bull condemned the practice. (Jansen, “Medieval

\textsuperscript{259} Ibid., 15–25. See Appendix 1, Plan 6.

\textsuperscript{260} C. H. Lawrence, \textit{Medieval Monasticism: Forms of Religious Life in Western Europe in the Middle Ages}, 3rd ed, Medieval World (Harlow, England ; New York: Longman, 2001), 222. The Carthusian order is emblematic of this change, moving away from a constant communal life to an existence of continuous individual seclusion.
Monastic Dormitories,” in Studies in Cistercian, 75) Frustratingly, she gives no more explanation than offering that it was representative of a general trend towards privacy. In a slightly more detailed explanation, Lawrence connects the relaxing of discipline at many Benedictine monasteries with a “general dilution of community life in favour of the individual. The most conspicuous breaches in the coenobitic principle were over privacy and individual ownership,” with common dormitories split into individual rooms. “Monastic life in these conditions resembled that of a college of secular clergy.” This fits well with the changes that appear to have taken place at St Mary in the Horsefair, as a communal dwelling was replaced by a collection of individual apartments. An almshouse and chantry at Ewelme constructed in the 15th century exhibits a similar quadrangular form as the later design of St Mary, albeit on a much grander scale. Here, thirteen paupers were housed in individual rooms around a large courtyard. The building included an attached church. The individual was crucial for a design such as this, a far cry from the large, open halls of St Leonard’s and St Mary Spital. The thirteen men, for no women were admitted to this house, had to fulfill a number of qualifications. They needed to be poor, to be free of “leprosy or any other intolerable sickness,” and appointed or recommended by some person of prominence. The example of Ewelme and the arguments of Lawrence support each other. The layout suggests a preference for privacy, an emphasis on the importance of private devotion and prayer. The inmates at Ewelme received a stipend and housing, but were forbidden to take outside work or beg. As

261 Ibid.
263 Ibid., 112–13.
the house was also a chantry, they would then have been expected to spend time offering prayers for the founding family.\textsuperscript{264} The preference for local charity work which may well have spurred the foundation of York’s \textit{maisons dieu} is also applicable to Ewelme. By housing a small, fixed number of inmates in individual houses, the founders could be sure that those admitted would reflect well on them, and perform their expected duties effectively. These poor were selected to ensure that they were deserving of the benefactor’s charity.\textsuperscript{265}

A hospital like St Leonard’s was certainly more visible in the city’s geography, but it was not necessarily the central focus of people’s charitable giving. The more local \textit{maisons dieu} would have featured more prominently in the daily lives of York’s citizens, as their inhabitants would have been begging for alms at the surrounding residences. The founding statues of the Saffron Walden almshouses offer an excellent example of the mentality behind these small, local institutions:

\begin{quote}
The pious citizens of the parish “decided to erect certain well-built houses to the honour of God and his glorious mother for the refuge and support of thirteen paupers… who are to comprise the more indigent individuals, namely such as are decrepit, blind [and] lame, whether from the fifty-two poorer persons of the town or from elsewhere, as may seem most expedient to the… custodians and governors.”\textsuperscript{266}
\end{quote}

The traditional apostolic community of thirteen paupers can be seen as similar to the situation in leper hospitals, where the inmates took on a spiritual significance in addition to their individual identity. Here, of course, the inhabitants would not have

\textsuperscript{264} Ibid., 142.
\textsuperscript{265} See Appendix 1, Plans 6-8.
been as potent icons as lepers, but they still worked as a way for a community to recreate Christian scriptural traditions, bolstering the spiritual significance of the almshouse inmates, which in turn made their prayers on behalf of the community more powerful. And familiarity with the local poor enabled the charitable giver to know that their gift was going to a trusted recipient, instead of possibly being spent on some unknown vagrant. As one of the commentaries on the *Decretum* argued in the 12th century, one ought to give to one’s own before strangers, to those who are familiar before those who are unknown. This also ties into the division of the poor into those deserving and undeserving of charity, for the local, well-known pauper or aged servant who was the target of *maisons dieu* and almshouses could be trusted as a recipient of charity. The smaller hospital foundations, like parish churches, thus would have been more trustworthy targets for charitable donations, as one would be more likely to know those to whom one was giving. Of course, this did not prevent everyone from donating outside their immediate surroundings. Leper houses, by virtue of their powerful symbolic meaning, were popular targets for alms. And one could, for instance, endow a bed at St Leonard’s, giving the donor the power to specify who might occupy it.

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Conclusion

While the timeline of this thesis has been rather fluid, going back to roughly the eleventh or twelfth centuries, the end is more concrete. The dissolution of the monasteries under King Henry VIII (1509-1547) marks an appropriate boundary for the scope of this thesis. Many hospitals in England, such as St Leonard’s and St Mary in the Horsefair, were shuttered during this period from 1536 to 1541. Despite the fact that hospitals generally were less cloistered or isolated than monasteries, they were monastic enough to suffer seriously during this period. The dissolution began with an act of parliament in 1536 allowing the Crown to dissolve houses with incomes of less than £200, which meant it applied to nearly every hospital foundation. “The York hospitals were dissolved over a score of years, first St. Nicholas’ which had been annexed to Holy Trinity Priory for a century or more. The last to go . . . was the little hospice of St. Mary the Virign in Bootham for chantry chaplains and aged and infirm priests: it was adapted to a shelter for blind priests.”268 As one of the major purposes of the dissolution was to bolster the Crown’s finances, it is no surprise that wealthy foundations like St Leonard’s were shut down. This is despite the fact that by this point, this formerly wealthy hospital was quite impoverished. “By the 16th century… the *Valor Ecclesiasticus* only shows a clear income of £309 2s. 11½d., or less than a third of that in 1280, not even allowing for the enhanced value of money.”269 While it might have been the case that many of these foundations were on their way out by the

269 Page, “Hospitals: York.”
16th century, their closure was followed by numerous riots in York, as they had been part of a series of religious foundations that were some of the most prominent landmarks of the city. And even if St Leonard’s was taking in fewer inmates, there was no comparable institution to take over its duties. Almshosues and maisons dieu, mostly unaffiliated with the church, survived. But these were not on the scale of St Leonard’s or St Mary Spital.

Hospitals were founded in England in great numbers through the 11th to the 15th centuries. In just the years between 1151 and 1200, 191 hospital foundations were created in England alone. The vast number of these institutions speaks not only to their popularity as a form of religious foundation, but as they were primarily concerned with providing some succor to impoverished and sick populations they offer an opportunity understand these marginal populations, who remain essentially invisible in the historical record. Hospitals were founded with considerable awareness for whom they were meant to provide care; there were hospitals for lepers, for elderly priests, for widows, for orphans, and for the sick and poor in general. Some combined multiple functions, such as St Leonard’s, but none were willing to accept just anybody. This is because charity, holding a crucial place in Christian life and practice, made demands on those who would seek to receive it. Hospital foundations reveal who was considered deserving of charitable aid, and who was not. Leper houses were perhaps the easiest in this regard, for the disease is a clear physical marker of lepers’ suffering. But lepers and other populations deserving of charity were not simply accepted and aided. They took on a variety of roles within medieval

270 Dean, *Medieval York*, 104.
society, for through their indigence they were understood to be more spiritually powerful, or significant. This is a strange concept, but one that has its foundations in the very earliest Christian writings. Christianity was a religion that appealed to those in marginal positions within society, for it offers the vision of an afterlife, rewarding those who were deserving in this life. And as scripture makes clear, with the parable of the camel and the needle and Lazarus and Dives, if the wealthy could make it into heaven it was certainly supposed to be harder for them, requiring effort and action. But those who, like Lazarus, were subjected to a miserable life in this world could look forward to a corresponding benefit in the next. The rich could discharge their obligation through charitable acts, and the indigent through using their spiritual import on behalf of these generous donors by praying for their souls. This created a reciprocal relationship, but one which was based on an expectation that the recipient of charity was deserving of said charity. For a beggar faking an injury would not have the same religious influence as one who was truly crippled.

The medieval hospital was a place where this relationship, including the judgement on the part of the donor, unfolded. Examining hospital foundations in a whole range of areas, from the circumstances of their creation to their architectural design and evolution, allows for a more complete understanding of how marginal populations were treated and conceptualized in medieval society. And beginning this exploration of hospitals with the complicated and nuanced conceptions of poverty in medieval Europe can provide explanations for choices in hospital design and development. This thesis has attempted to draw together work on poverty, on hospitals, and on urban society, for all three of these are closely connected. The
hospital cannot be seen as existing in isolation, for it was an important part of a community, and supported because of this. As hospitals were primarily urban foundations, the city of York was chosen as a geographic focus for it can boast of once having large number of hospitals and now possesses a relative wealth of scholarship relating to these institutions.

One question that has arisen out of this thesis, which I have attempted to address if not answer, relates to the architectural development of religious houses. Hospitals, like monasteries, exhibit a tendency to move away from communal dormitories, dividing their spaces into individual apartments. This appears to have been due to the increasing value placed on privacy and individual religious devotion, but the ultimate cause of this transformation is not clear. Further exploration of this topic could prove interesting.

While this thesis remains firmly focused on the past, it touches on a number of areas that have modern-day importance. Obviously, care for the poor and indigent is not an issue that has been resolved. While certain aspects of medieval hospitals are clearly lacking in comparison to today, namely the quality of medical treatment, their interactions with the poor and sick should not be seen as backwards and medieval, in the unfortunate modern meaning of the word. The whole concept of purgatory and efficacy of prayer is less central in modern society, but for the medieval community, the prayers of those in hospitals were of benefit to all. How else to understand the ubiquity of these foundations, especially if combined with monastic foundations, which they often resembled. These institutions provided “a haven of Christian life,” offering inhabitants “an opportunity to save their souls and, at the same time, to
celebrate Divine Service which, generation after generation, would rebound to the benefit of all people, living and dead.” The leper might have been physically repellent in the later stages of the disease, but his or her spiritual importance was so highly valued that society provided for them, supplying housing, food and drink, and alms. Even in less extreme cases, it would be wrong to conclude that the prayers of those in hospitals were benefitting only the wealthy donors; every person could stand to benefit. Thomas Gryssop, a poor chapman from York who died in 1446, left five shillings to the poor in the city’s *maisons dieu*. Even those owning little were involved in giving to hospitals, for they understood that their gifts would benefit them, the receiver, and the community by ensuring these places for prayer could continue to function. There were certainly elements of this system of relationships, such as the rejection of certain groups, that can appear problematic. Few hospitals would accept those who were actually seriously ill or those who were understood to be vagabonds, or transient poor. And St Augustine’s proscription against giving to sinful professions was well-known to medieval theologians. Despite this, the medieval hospital should be seen, not as a place of backwards practice and misery, but as a key component in a vibrant system of charity that benefitted its givers, recipients, and the communities of which they were part. The poor, sick, and crippled were not excluded from society; they were embraced as a crucial component of a well-functioning religious community.

271 Orme and Webster, *The English Hospital 1070-1570*, 205.
272 Stell and York Archaeological Trust, *Probate Inventories of the York Diocese, 1350-1500*, 573. Chapman is another name for a merchant or a trader.
Appendix 1: Maps & Plans

Map 2. Locations of hospitals in the city of Norwich, pre-dissolution. Note the location of the leper houses, surrounding the city at nearly every gate. Only one of the leper hospitals, St Mary Magdalen Sprowston, was any serious distance from the city’s walls. Carole Rawcliffe, *Leprosy in Medieval England* (Woodbridge, UK; Rochester, NY: Boydell Press, 2006).
Plan 1. A reproduction of the Plan of St Gall. The infirmary cloister is in the top left corner, and includes its own chapel. The intended interior designs of the infirmary buildings cannot be known, but it would likely have resembled other monastic infirmaries in following an open-ward plan. Image from http://www.stgallplan.org/en/plan.html
Plan 2. The long, open-ward infirmary of Tonnerre. Compare to Plan 4, the infirmary of Rievaulx. Both would have had some interior division, but these would likely have been temporary and made from wood. There is a chapel included inside the hall, allowing those confined to bed to participate in services. Little sense of a claustral area.

http://healtharchitecture.wikifoundry.com/page/Open+Ward+Concept
Plan 4. The infirmary cloister during the 12th century at Rievaulx Abbey, Yorkshire. This was an openward infirmary, with its own claustral area for the inmates (see Plan 1). The church would have been located above this section of the abbey, only a short walk away. Eventually a part of the Abbot’s residence would be turned into a chapel, and the top-left infirmary door closed off. Peter Fergusson and Stuart A. Harrison, Rievaulx Abbey: Community, Architecture, Memory (New Haven, CT: Yale University Press, 1999), 110.
Plan 5. St Leonard’s Hospital, York. Nothing survives from the center of the compound, but it is fairly certain this would have included, among other buildings, a sizable church. The infirmary hall itself is open, connected to two chapels, possibly placed in this rather odd configuration (as opposed to at the ends, see Plan 3) due to lack of space. The area around the undercroft may well have been a residence for the hospital’s staff. The existence of a cloister is unknown. Gareth Dean, *Medieval York* (Stroud: Tempus, 2008), 100.
Plan 6. Two architectural stages of the small hospital of St Mary in the Horsefair. The first, 3.2, is from the 14th century, the initial design of the hospital. Room A is thought to have been the dormitory/infirmary, and possible also a chapel. Room B was a series of domestic spaces, mainly for food preparation. In the second phase, 4.4, A has become a chapel, and C and D are residential and domestic spaces. The open-ward has evolved into a number of separate dwellings. Adapted from J. D Richards et al., *Union Terrace: excavations in the Horsefair* (London: Published for the York Archaeological Trust by the Council for British Archaeology, 1989), 16.
Plan 7. The Chartreuse de Bourgfontaine, a Carthusian monastery in northern France founded in the 14th century. Individual cells do not survive, but as this plan shows, they would have surrounded the large central yard. According the Carthusian tradition, each monk would have his own dwelling, usually two floors and a small garden. Image credit: MonArch - Bonde/Maines.
Plan 8. The two floors of the God’s House (almshouse) at Ewelme, founded in the mid-15th century. There were thirteen dwellings for the thirteen paupers housed in this hospital, usually for life. There was a church to the north. John A. A. Goodall, *God’s House at Ewelme: Life, Devotion, and Architecture in a Fifteenth-Century Almshouse* (Aldershot, Hants, England; Burlington, Vt: Ashgate, 2001), 80.
## Appendix 2: Hospitals of York

<table>
<thead>
<tr>
<th>Dedication or Location</th>
<th>Founder or Patron</th>
<th>Founded</th>
<th>Dissolved</th>
<th>Inmates</th>
<th>Dependent or Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Peter</td>
<td>Athelstan, York Minister</td>
<td>936 (?)</td>
<td>1135</td>
<td>Poor, sick, infirm</td>
<td>York Cathedral</td>
</tr>
<tr>
<td>St Leonard</td>
<td>Minister, The Crown</td>
<td>1135</td>
<td>1539</td>
<td>Poor, sick, infirm</td>
<td>Austin</td>
</tr>
<tr>
<td>Corpus Christi and St Thomas the Martyr</td>
<td>Guild</td>
<td>by 1391</td>
<td>not suppressed</td>
<td>Poor, sick, infirm, travelers</td>
<td></td>
</tr>
<tr>
<td>Hertergate</td>
<td>Thomas de Howom</td>
<td>by 1390</td>
<td>16th c.</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>Holy Trinity, Fossgate</td>
<td>by 1373</td>
<td>not suppressed</td>
<td>Poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layorthorpe</td>
<td>John de Craven</td>
<td>by 1407</td>
<td>by 1535 (?)</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>Little Shambles</td>
<td>by 1407 (?)</td>
<td>Poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monk Bridge, St Leonard</td>
<td>by 1350</td>
<td>1547</td>
<td>Lepers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Street</td>
<td>John/Isolda de Acaster</td>
<td>c. 1397</td>
<td>16th c.</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>Peter Lane</td>
<td>John Dernyngton</td>
<td>by 1390</td>
<td>16th c.</td>
<td>Poor men</td>
<td></td>
</tr>
<tr>
<td>St Andrewgate</td>
<td>Cecily Plater</td>
<td>by 1390</td>
<td>16th c. (?)</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>St Anthony, Gillygate</td>
<td>by 1403</td>
<td>before 1429</td>
<td>Poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Anthony, Peaseholm</td>
<td>St Anthony Guild</td>
<td>c. 1446</td>
<td>16th c. (?)</td>
<td>Guild members</td>
<td></td>
</tr>
<tr>
<td>St Giles</td>
<td>by 1274 (?)</td>
<td>Poor men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Helen Fishergate</td>
<td>by 1333</td>
<td>Lepers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Katherine</td>
<td>by 1333</td>
<td>not suppressed</td>
<td>Lepers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St John the Baptist</td>
<td>Merchant Taylors</td>
<td>after 1389</td>
<td>not suppressed</td>
<td>Guild members</td>
<td></td>
</tr>
<tr>
<td>St Mary in the Horsefair</td>
<td>Robert Pickering, Dean</td>
<td>1318</td>
<td>by 1556</td>
<td>Poor priests</td>
<td></td>
</tr>
<tr>
<td>St Mary Magdalene Bootham</td>
<td>by 1481</td>
<td>c. 1547</td>
<td>Lepers</td>
<td></td>
<td></td>
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<td>----------------------------</td>
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<tr>
<td>St Nicholas</td>
<td>St Mary’s Abbey, City of York</td>
<td>1088-1112 by 1422</td>
<td>by 1422 1537</td>
<td>Lepers, later for sisters</td>
<td>Austin, Holy Trinity Priory</td>
</tr>
<tr>
<td>Stonebow Lane</td>
<td>by 1362</td>
<td>(?)</td>
<td>Poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ousebridge</td>
<td>City of York</td>
<td>13th c.</td>
<td>(?)</td>
<td>Poor, later women</td>
<td></td>
</tr>
<tr>
<td>Walmgate Bar</td>
<td>(?)</td>
<td>(?)</td>
<td>Poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitefriars Lane</td>
<td>John Holme, gentleman</td>
<td>1472</td>
<td>Not suppressed (?)</td>
<td>Poor</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1.** List of the hospitals of York. This is a combination of work by Clay, Knowles/Hadcock, and Cullum. It is not complete – the lists I have worked from do not agree in many cases, for they all use different methods of categorizing these foundations. The hospitals which have an actual founder’s names are primarily *maisons dieu*. Austin indicates that they follow the Rule of St Augustine. Cullum, “Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547,” 459-61; Knowles and Hadcock, *Medieval Religious Houses, England and Wales*, 322-24; Clay, *The Mediaeval Hospitals of England*, 335-36.
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