



Project
MUSE[®]

Today's Research. Tomorrow's Inspiration.

The Earliest Hospitals in Byzantium, Western Europe, and Islam

Hordey, Peregrine.

Journal of Interdisciplinary History, Volume 35, Number 3, Winter 2005, pp. 361-389 (Article)

Published by The MIT Press

The Journal
of
Interdisciplinary History



 For additional information about this article

<http://muse.jhu.edu/journals/jih/summary/v035/35.3hordey.html>

Peregrine Horden

The Earliest Hospitals in Byzantium, Western

Europe, and Islam What difference did hospitals make? Questions in that form have a distinguished pedigree in late antique studies. As Judge reported in 1980, “When I once told A. H. M. Jones that I wanted to find out what difference it made to Rome to have been converted [to Christianity], he said he already knew the answer: None.” In 1986, MacMullen’s more open-minded enquiry into the possible impact of the newly established religion on fourth-century changes in secular life carried the title, “What Difference Did Christianity Make?” My appropriation of MacMullen’s phrasing pays oblique homage not only to him but to Brown, whose recent work suggests that it may not be the appropriate question to ask of the period. The implied imagery of Christianity as a single powerful tide, progressively sweeping away the vestiges of paganism, and thus effecting a distinct and measurable difference, owes too much to the primary-colored triumphalist narrative of “Christianization” bequeathed by fifth-century historians. It does not reflect the complex grisaille of the actual religious history of the fourth and fifth centuries.¹

Does the history of hospitals belong under the aegis of MacMullen or under that of Brown? Can we assess the impact of these institutions for the overnight accommodation and relief of the poor and sick from the mid-fourth century onward? Or is the “problem of hospitals” as labyrinthine as “the problem of Christianization”? This article addresses the question of impact while keeping a skeptical eye on its validity. The inspiration

Peregrine Horden is Reader in Medieval History, Royal Holloway, University of London. He is co-author, with Nicholas Purcell, of *The Corrupting Sea: A Study of Mediterranean History* (Malden, Mass., 2000); editor of *Music as Medicine: The History of Music Therapy since Antiquity* (Aldershot, 2000).

© 2004 by the Massachusetts Institute of Technology and The Journal of Interdisciplinary History, Inc.

1 Edwin A. Judge, *The Conversion of Rome: Ancient Sources of Modern Social Tensions* (Sydney, 1980), 10, quoted by Ramsay MacMullen, *Christianizing the Roman Empire (AD 100–400)* (New Haven, 1984), 154, n. 25; *idem*, “What Difference did Christianity Make?” *Historia*, XXXV (1986), 322–343; Peter Brown, *Authority and the Sacred: Aspects of the Christianisation of the Roman World* (Cambridge, 1995), x, 6–7, 47.

comes from studies of hospitals during the later Middle Ages and Renaissance, as well as the nineteenth century, that make them central to social and religious history but remain chary of according them primacy in the explanation of major change. My approach is deliberately broad and comparative, encompassing nascent traditions of hospital foundation in early Byzantium (late antiquity), early medieval Western Europe, and (to a lesser extent) the early Islamic caliphate, as well as in Jewish communities.²

HOSPITALS IN THE ANCIENT CITY To ask what difference hospitals made is immediately to prompt other questions: Difference of what kind? And to whom? Brown's latest work offers an answer in terms of "crowds and power" in the urban churches of the post-Constantinian world. What once may have seemed like an almost natural evolution from a pagan to a Christian "folk sociology" Brown presents instead as a revolution, in which the bishops were the leaders. One of the means by which they asserted their leadership, from the mid-fourth century onward, was the founding and patronage of hospitals. The self-image of the inhabitants of the ancient city had space for local notables sharing a common rhetorical culture with provincial governors and imperial courtiers. In both center and periphery, the "big men" spoke the same language. At a local level, this trait distinguished them from those who entrusted themselves to their care and "nourishment." In this collective representation of urban society, the poor had no conceptual place. Those who could expect care did so as citizens, not as paupers—that is, on legal grounds, not economic ones. The establishment of the Christian Church by Constantine helped to pave the way for Christian bishops to usurp the already weakened power of local lay notables, through a "Christian populism." They deliberately replaced a civic model of society with a universal citizenship (a prelude to that of heaven), in which the poor emerged from the conceptual shadows to symbolize the Church's embrace of society as a whole. The bishop as "lover of the poor" was a stronger image

2 Brown, *Authority*, 3; Carole Rawcliffe, *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital: St Giles's, Norwich, c. 1249–1550* (Thrupp, 1999); John Henderson, *The Renaissance Hospital* (New Haven, forthcoming); Marco H. D. van Leeuwen, *The Logic of Charity: Amsterdam, 1800–1850* (Basingstoke, 2000). Since the discussion that follows touches too many areas and periods to be fully documented herein, footnotes henceforth are largely confined to recent work that opens up, to the non-specialist, both the primary evidence and a wider secondary literature.

than that of the notable as “nourisher of the citizen body” in both its emotional charge and its social ramifications. It shattered the ancient civic model.³

Under Constantine and Constantius II, churches and clerics benefited enormously from tax immunities. They needed a highly visible symbol of how they were deploying the wealth generated not only through these immunities but also through the patronage of emperors and the much smaller donations of ordinary citizens. Since hospitals highlighted the poor as the defining group in the new Christian representation of society, they legitimated the Church’s wealth by connecting it with purposes that few could reasonably question. Although many scholars have noted the changes in the late antique city that accompanied the rise of Christianity, Brown is distinctive in interpreting these changes, less as merely epiphenomenal to the increase in the urban poor and as the obvious culmination of pre-existing Christian charity than as ingredients in a deliberate episcopal arrogation of power, both material and symbolic. So Brown’s answer to the question, “What difference did hospitals make?,” would be that hospitals stood for, and contributed to, a quiet social revolution in the ancient city.⁴

The answer, however, should have two riders: (1) it is not specific to hospitals; (2) it does not necessarily implicate the poor directly. Whatever pleasure the poor took in their novel symbolic standing, they were not inevitably less hungry or more powerful. In the Christian crowds over whom and through whom bishops exercised power, the heavyweight supporters who could intimidate the opposition were not hospital patients. They were—in Alexandria, at least, and perhaps elsewhere—the corps of hospital stretcher bearers. They, rather than the sick, represented the hospitals’ “clout.”⁵

3 Brown, *Poverty and Leadership in the Later Roman Empire* (Hanover, 2002), partly anticipated in *idem*, *Power and Persuasion in Late Antiquity: Towards a Christian Empire* (Madison, 1992), 75–103.

4 Contrast Evelyne Patlagean, “The Poor,” in Guglielmo Cavallo (ed.), *The Byzantines* (Chicago, 1997), 18; *idem*, *Pauvreté économique et pauvreté sociale à Byzance 4e–7e siècle* (Paris, 1977), 185–188, 231–235. For critical reflections on Brown’s possibly too reductive analysis of power and its uses in the late antique city, see Éric Rebillard, “La ‘conversion’ de l’empire romain selon Peter Brown,” *Annales* (July/August, 1999), 813–823. See also, anticipating Brown, Brian E. Daley, “Building a New City: The Cappadocian Fathers and the Rhetoric of Philanthropy,” *Journal of Early Christian Studies*, VII (1999), 432–433.

5 Christopher Haas, *Alexandria in Late Antiquity: Topography and Social Conflict* (Baltimore, 1997), 235–238, 314.

Brown thus views poverty and charity through the prism of a broad ideology. Although he by no means sets aside painful social and economic realities, he is more concerned with the conceptual space occupied by poverty in the “self-image of the age.” “In a sense,” he ventures, “it was the Christian bishops who invented the poor.” The related but slightly different focus of the present article is the practical difference that hospitals might have been perceived to make, by their founders and by the recipients of poor relief and charity.⁶

HOSPITALS AND SOCIAL SPACE A definition of *hospital* that has the merit of forming a transition from Brown’s conceptual account to my own, can be couched in terms of the “production of space”—physical, not conceptual. A hospital is a pauper enclosure; it gathers and, for a time (perhaps only overnight), removes the poor from exposure to the elements and the view of society, though not in the Foucauldian manner of a great *renferment* of beggars behind hospital walls. (Such containment was seldom attempted on any scale in the fourth or fifth centuries any more than, pace Foucault, in the seventeenth.) Rather, the hospital defines a new space for the poor or sets barriers around a space already loosely demarcated by custom as the resort of the sick or needy. In major cases, such as St. Basil’s cluster of philanthropic foundations outside Caesarea in the early 370s, hospitals can even provide new focuses for urban or sub-urban space. The “Basileias” was lauded as a “new city” not only because, in Brown’s terms, it exemplified the novel significance of episcopal “love of the poor” but also because, like some extramural shrine or new church building, the hospital complex offered a topographical challenge to the established center of Caesarea.⁷

The hospital as a means of reconfiguring urban space, however, did not emerge in isolation. It belongs in the context of parallel transformations that are all part of “the problem of Christianization.” Since the fourth century, hospitals have been

6 Brown, *Poverty*, 8.

7 Henri Lefebvre, *The Production of Space* (Cambridge, Mass., 1991). On Michel Foucault, see Roy Porter, *Mind Forg’d Manacles: A History of Madness in England from the Restoration to the Regency* (London, 1987), 7–9. Basil’s philanthropic foundations are discussed in Brown, *Poverty*, 38–42; Susan R. Holman, *The Hungry Are Dying: Beggars and Bishops in Roman Cappadocia* (New York, 2001), 74–75; Timothy S. Miller, *The Birth of the Hospital in the Byzantine Empire* (Baltimore, 1997; orig. pub. 1985), 85–88.

imaged, not altogether fairly, as stairways to heaven, and the obvious context for the hospital as distinct space is death. Rebillard painstakingly examined the limited evidence for the development of ecclesiastical cemeteries for the poor and strangers. The chronology of this development closely matches what an influential monograph calls “The Birth of the Hospital in the Byzantine Empire.” It seems clear that in the early fourth century, Constantine had instituted a system for the provision of free burial to the inhabitants of Constantinople. Yet, not until the latter part of that century does any sign of burial grounds set aside for indigents and strangers appear. The story of early hospitals is similar.⁸

HOSPITAL CHRONOLOGY The hospital chronology that follows starts in the early Byzantine empire and ends in the early Middle Ages. Its purpose is not to repeat a well-established narrative but to bring out some of the geographical and chronological gaps that receive scant attention in modern accounts and to explore the circumstances that seem to have made the establishment of hospitals desirable to their founders. Brown’s explanation of the first Christian hospitals privileges their furtherance of an urban revolution; it remains to be seen how well such an approach applies to later hospitals. For the moment, therefore, we do not enter the world of hospital patients. Their perceptions ought not be conflated with those of their benefactors. Studies of later periods show how different the two sets of perceptions could be.⁹

It is fruitless to search for one specific instance with which the Christian charitable tradition of hospital foundations can be said to begin. No one seems to have claimed absolute priority. Perhaps the infirmary of what is usually considered the first monastery, established by Pachomius at Tabennesi (north of Thebes in Egypt), should count as the first Christian hospital. If so, the institution dates from around 325 C.E. But the evidence of that infirmary, like

8 Rebillard, “Église et sépulture dans l’antiquité tardive (occident latin, 3e–6e siècles),” *Annales* (September/October 1999), 1037–1038; *idem*, “Les formes de l’assistance funéraire dans l’empire romain et leur évolution dans l’antiquité tardive,” *Antiquité tardive*, VII (1999), 274–278. For the hospital as the “easiest way up to heaven,” see Gregory Nazianzen, *Oratio*, 43.63 (*Funeral Oration for Basil the Great*), in Jean Bernardi (ed. and trans.), *Grégoire de Nazianze, Discours 42–43* (Paris, 1992), 262.

9 Sandra Cavallo, *Charity and Power in Early Modern Italy: Benefactors and Their Motives in Turin, 1547–1789* (Cambridge, 1995).

much else in the Pachomian dossier, is ambiguous and, worse, may provide information only about developments after his death. In any case, it was not a “public” hospital for the poor. Since the first known hospital was erected by Leontius of Antioch (in modern south-eastern Turkey), bishop from 344 to 358, the year 350 seems to be an acceptable round date for the emergence of *xenodocheia* or *xenones*, hospitals for strangers or migrants (at least in light of the evidence). At about the same time, a deacon called Marathonius, protégé of the newly elected Bishop Macedonius, was put in charge of the hospitals and monasteries of an extreme wing of urban ascetics in Constantinople. A little later, in the late 350s or 360s, Eustathius of Sebaste (Sivas in northern Turkey) built a *ptochotropheion*, literally a place in which beggars were nourished. Shortly thereafter, St. Basil established his charitable “multiplex” for the sick, the paralyzed, lepers, and strangers, as a “new city,” in extramural Caesarea.

The evidence for Leontius, Marathonius, and Eustathius is brief, partial, and vulnerable to skepticism. We cannot reconstruct the ideas and decisions that preceded the foundations. Some historians have seen the development of the hospital as a sign of urban monasticism’s commitment to charity. Others have related it to the rival claims to popular support of orthodox and Arian “heretics” in the fourth-century Church. Brown recently nudged the pendulum in the direction of imperial patronage as the context for, above all, Basil’s foundations. The dispute cannot be properly conveyed, let alone settled, without a thorough rehearsal of textual minutiae that is unnecessary at this point. What matters for present purposes is that, on any plausible account, hospitals—whether for the poor or the sick—seem to have developed suddenly and in specific areas. If the poor of this period are an invention of bishops, so too, with all deference to Pachomius, is the hospital.¹⁰

10 For a fuller discussion of the evidence, see Horden, “The Christian Hospital in Late Antiquity: Break or Bridge?” in Florian Steger and Kay Peter Jankrift (eds.), *Gesundheit—Krankheit: Kulturtransfer medizinischen Wissens Von der Spätantike bis in die Frühe Neuzeit* (Cologne, 2004), 77–99. For Pachomius, see Andrew T. Crislip, “The Monastic Health Care System and the Development of the Hospital in Late Antiquity,” unpub. Ph.D. diss. (Yale University, 2002), 20; the “first” Greek and Bohairic *Lives* of Pachomius (sections 28, 26), in Armand Veilleux (trans.), *Pachomian Koinonia* (Kalamazoo, 1980), I, 315, 48. See also Demetrios J. Constantelos, *Byzantine Philanthropy and Social Welfare* (New Rochelle, 1991; orig. pub. 1968), 113–162; Miller, *Birth*, 21–22 (favoring as explanation the competition

The year 350 falls within the reign of Constantius II. Despite the enormous patronage that Constantine had expended on the newly established Christian Church, hospitals did not flourish in his time. Nor had they developed in the early (pre-Constantinian) Church, although it was clearly capable of elaborate charitable distributions. Nor, seemingly, were they a prominent feature of Jewish communities in rabbinical times.¹¹

Why did the invention occur where it did? If the hospital was a visual justification of imperial largesse to the Church, a symbol of its dedication to the citizen body, its first appearance would have been more likely in Constantinople, and in a more emphatic manner. Perhaps the pressure to justify and symbolize was greater in smaller centers, where the requisite transfer of resources was relatively greater. Regardless, the invention seems to have spread rapidly. Indeed, it may have arrived in the Christian kingdom of Armenia at about the same time as it arrived in the capital.¹²

The next discernible phase in early hospital history occurred outside the eastern empire. The hospital was received as a novelty, the adoption of which was presumably thought to make an important difference, whether to inmates or to founders. By the end of the fourth and the beginning of the fifth century, it had rapidly diffused around the Mediterranean, to Italy (Ostia and Rome) and North Africa (Augustine's Hippo)—areas in contact with Byzantium. It became worth asserting, as Jerome did of Fabiola, that “*primo omnium nosokomion instituit*”; it became worth proclaiming someone as “the first of all to found a hospital.” Jerome's accuracy in naming Fabiola does not matter. What does matter is his notion that “*primo omnium*” deserved recognition.¹³

for pauper support of orthodox and Arians); Brown, *Poverty*, 36–38. The explanation in terms of asceticism was propounded by Gilbert Dagron, “Les moines et la ville: le monachisme à Constantinople jusqu'au concile de Chalcédoine (451),” *Travaux et Mémoires*, IV (1970), 229–276, and criticized in Brown, *Poverty*, 38. See also Daniel Caner, *Wandering, Begging Monks: Spiritual Authority and the Promotion of Monasticism in Late Antiquity* (Berkeley, 2002), 96–101, 175–176.

11 Brown, *Poverty*, 2, 25, 34; Horden, “Christian Hospital,” 88; Eusebius, *Ecclesiastical History*, VI.43.11, in Eduard Schwartz and Theodor Mommsen (eds.), *Die griechischen christlichen Schriftsteller* (Berlin, 1999), VI.2 618.

12 For Armenia, see Nina G. Garsoïan (trans.), *The Epic Histories Attributed to P'awstos Buzand* (Cambridge, Mass., 1989), 115, 211–212.

13 Vivian Nutton, “From Galen to Alexander: Aspects of Medicine and Medical Practice in Late Antiquity,” *Dumbarton Oaks Papers*, XXXVIII (1984), 9; for Hippo, Horden, “Christian

Despite this emphatic start, the northern and westward lines of transmission soon petered out, as if the new “hospital idea” had become less attractive. The hospital in Hippo inaugurated no vigorous North African tradition of foundation. Outside Rome few Italian hospitals emerged until the Lombard period. In Visigothic Spain, the only prominently attested hospital is that of Bishop Masona of Mérida, who died in 605. In Gaul, no hospital, either monastic or episcopal, is evident before 500—that is, almost a century after the idea started its westward spread. The next-earliest recorded foundation, that of Caesarius of Arles, marks the beginning of a more resilient hospital tradition in the Merovingian realms than is detectable elsewhere in the post-Roman West. But this tradition embraced only thirty-four documented establishments.¹⁴

In any given period or place within Late Antiquity or the early Middle Ages, many more hospitals than those on record may have existed. Counting establishments, even for the much-better-documented later Middle Ages, is fraught with difficulty, because the foundations are often obscure and ephemeral. Yet the early hospital trail is so quickly and comprehensively lost as we follow it across the Mediterranean from east to west and south to north that it is hard not to see the transmission of the idea as having faltered.

In other directions, it proved more resilient. Hospital historians, like other early medievalists, are familiar with the adage that the evidence always improves toward the east, in cultural terms if not always strictly in geographical ones. To get some idea of what the interior of a small hospital was like during the early Byzantine period means looking not to Greek evidence but to that written in Syriac. The *Life* of Rabbula of Edessa (modern Urfa), for example, records the clean bedding and clothes available to the inmates of Rabbula’s two hospitals—one for men and one for women—and

Hospital,” 97; Jerome, *Letter 77.6, Sancti Eusebii Hieronymi epistulae*, in Isidore Hilberg (ed.), *Corpus Scriptorum Ecclesiasticorum Latinorum* (Vienna, 1996; orig. pub. 1911), LV, 43.

¹⁴ Thomas Sternberg, *Orientalium More Secutus: Räume und Institutionen der Caritas des 5. bis 7. Jahrhunderts in Gallien, Jahrbuch für Antike und Christentum Ergänzungsband* (Münster, 1991), XVI, which is of much wider geographical reference than its title suggests. For the “oriental custom” in hospital endowment in Francia, see *ibid.*, 277–279; for Caesarius, 196–199. On Spain, see Peter Heather (ed.), *The Visigoths from the Migration Period to the Seventh Century: An Ethnographic Perspective* (Woodbridge, U.K., 1999), 196, 272; *Vitas Sanctum Patrum Emeritensium*, V.3, in A. Maya Sánchez (ed.), *Corpus Christianorum* (Turnhout, Belgium, 1992), CXVI, 50–51; A. T. Fear (trans.), *Lives of the Visigothic Fathers* (Liverpool, 1997), 74–75.

the attentive and kindly regime of the deacons and deaconesses employed in them. Such establishments and their later imitations in Byzantine Syria and Egypt, as well as in Sassanid Iran, form the link between the hospital history of Byzantium and that of Islam.¹⁵

Islamic lands are the next to pick up the thread of the hospital idea in a relatively clear-cut manner. In general, a hospital was thought to make a difference if the idea of it seemed worth adopting, as in Italy and Gaul. But the story of the Islamic hospital is slightly different. It indeed had a direct and relatively speedy transmission, but in what proves to be only legend. That is, a retrospective account elaborated during the Middle Ages held that Greek physicians brought the idea of the hospital to the Persian court at Jundeshapur in Khuzistan. There, during the second and third centuries, two shahs contributed to the development of a hospital and medical school. The school's preeminence was supposedly reinforced during the sixth century by the arrival of Nestorian Christians, and, after the Arab conquests, the associated hospital was the chief model for the more elaborate foundations of Islamic caliphs.¹⁶

The durability of this myth of origins shows how readily the hospital could be conceived as an invention passed from one specific location to another. The narrative was so seductive in its simplicity that only recently has a more messy and realistic explanation been able to supplant it—in short, the existence of numerous Christian charitable foundations active within the land of Islam after the conquests and the plurality of medical centers that probably served as inspiration for Islamic foundations. That the Arabic word for a hospital, *bimaristan*, means “house [or place] of the sick” in New Persian points to a connection between the hospitals of Iran/Iraq and the first Islamic ones, but the former would also have been Christian. Several different kinds of Zoroastrian charitable foundation were characteristic of pre-Islamic Iran. But the hospital does not seem to have been among them. A sixth-century Syriac chronicle announces that the Shah Chosroes Anushirvan, “on the advice of the Christian doctors who are close

15 Susan Ashbrook Harvey, “The Holy and the Poor: Models from Early Syriac Christianity,” in Emily Albu Hanawalt and Carter Lindberg (eds.), *Through the Eye of a Needle: Judeo-Christian Roots of Social Welfare* (Kirkville, 1994), 49–51.

16 Friedrun R. Hau, “Gondeschapur: eine Medizinschule aus dem 6. Jahrhundert n. Chr.,” *Gesnerus*, XXXVI (1979), 98–115.

to him, has now, departing from custom, made a hospital [*xenodocheion*].” It had 150 camels to transport its supplies and a staff of twelve doctors. The implication of the passage is that, in founding this hospital, the king was departing not only from his own custom, but from Sassanian royal custom generally. Thus did the hospital idea appear to leap from the eastern Christian to the Zoroastrian world, although not at the time or place that the myth of origins asserted.¹⁷

It did not take root. Indeed, another long gap in hospital history ensued. Christian hospitals formed a background continuum. But no late Sassanian or early Islamic rulers (or other benefactors) seem to have founded any hospitals between the mid-sixth and the late eighth or early ninth century. No Umayyad or early Abbasid hospitals are in evidence until the Barmakid hospital in ninth-century Baghdad, the first Islamic hospital. Why the hospital was not a more immediately attractive expression of the Islamic ruling elites’ piety is a matter for conjecture. The explanation may lie with medical history, because (unlike those of Byzantium and the west) the typical Islamic hospital in such cities as Baghdad and Cairo came to be staffed by Galenic physicians. The absorption of the necessary Greek medical learning could not have occurred before the court-inspired translation movement of the later eighth century C.E.¹⁸

GLOBAL PERSPECTIVES The foundation of a hospital was a type of project that inspired imitation and recreation. It was special enough for contemporaries to record that someone was the first to build a hospital in a particular place. The hospital was an invention

17 Michael W. Dols, “The Origins of the Islamic Hospital: Myth and Reality,” *Bulletin of the History of Medicine*, LXI (1987), 367–390; Horden, “Nestorians, Gondeshapur, and Islamic Medicine: A Sceptical Comment,” unpub. paper (Cambridge, 1983); Lawrence I. Conrad, “The Institution of the Hospital in Medieval Islam: Ideals and Realities,” unpub. paper (London, 1985). On Zoroastrian charity, see Ehsan Yarshater (ed.), *Encyclopaedia Iranica* (Costa Mesa, Calif., 1991), V, s.v. “Charitable Foundations.” The quotation is from (pseudo-) Zacharias Rhetor, *Ecclesiastical History*, XII.7, in Ernest W. Brooks (ed.), *Corpus Scriptorum Christianorum Orientalium* (1921), II, 217–218. I am grateful to Andrew Palmer for help with the translation.

18 The supposed evidence for an early eighth-century Islamic hospital is neatly demolished by Conrad, “Did al-Walid found the First Islamic Hospital?” *Aram*, VI (1994), 225–244. For the Barmakid hospital, see Dols, “Origins,” 382–383. On the translation movement, a convenient and authoritative summary is Conrad, “The Arab-Islamic Medical Tradition,” in *idem* et al., *The Western Medical Tradition 800 BC to AD 1800* (Cambridge, 1995), 103–110.

of fourth-century bishops to the same extent that “the poor” were.

Was it really new? In a global context, the term *hospital* means a distinct and permanent structure for the overnight accommodation and relief of the poor and/or sick. Hospitals in premodern times were not obvious or natural things to build. They required a certain stable, usually urban economy; human and material resources for the buildings and their purpose; a perception of the inadequacy of dispersed forms of support; a belief that economies of scale were possible by the concentration of care within a building; and faith in the value of the project and its beneficiaries, whether spiritual or material.

All of these evaluations and calculations were rare in ancient and medieval times. In the New World, in pre-Columbian central Mexico, some bathhouses may have doubled as reception centers for the sick. In the Old World, the idea of the hospital does not seem to have occurred to the Babylonians or any other preclassical Near Eastern civilization, to the Egyptians, or to the ancient Greeks. Further east, hospitals were principally expressions of the charity of Buddhist rulers, as in India, Sri Lanka, and Cambodia. The hospitals that appeared in Hindu or neo-Confucian milieus likely reflected Buddhist influence. Thus can hospitals be found within the cultural realms of all the world religions, but the global map of their foundations has huge blanks on it until the formation of European overseas empires.¹⁹

One main exception outside the realms of world religions may hint at why hospitals have been so rare on a global scale. They appear in only highly restricted environments, which, in the ma-

19 Thelma D. Sullivan, “Tlazolteotl-Ixcuina: The Great Spinner and Weaver,” in Elizabeth Hill Boone (ed.), *The Art and Iconography of Late Post-Classic Central Mexico* (Washington, D.C., 1982), 19–22. For the preclassical Mediterranean and Middle East, I shall not use a footnote to try to prove a negative. There has been no proper comparative discussion of this subject since Hendrik Bolkestein, *Wohltätigkeit und Armenpflege im vorchristlichen Altertum: ein Beitrag zum Problem “Moral und Gesellschaft”* (Utrecht, 1939). Nor to my knowledge is there any reliable modern global survey. The literature is variable in quality and mostly elderly. See Karl Sudhoff, “Aus der Geschichte des Krankenhauswesens im früheren Mittelalter in Morgenland und Abendland,” *Sudhoffs Archiv*, XXI (1929), 165–166, 178; Reinhold F. G. Müller, “Über Krankenhäuser aus Indiens älteren Zeiten,” *ibid.*, XXII (1930), 135–151; Arthur L. Basham, “The Practice of Medicine in Ancient and Medieval India,” in Charles Leslie (ed.), *Asian Medical Systems: A Comparative Study* (Berkeley, 1976), 34–36. Dominik Wujastyk (trans.), *The Roots of Ayurveda: Selections from Sanskrit Medical Writings* (London, 2003), xv–xvi, offers an overoptimistic snapshot of the antiquity and diffusion of Indian hospitals.

jority of cases, derive from a particular inflexion of an ideology of charity. The ancient case is different, but the circumstances are no less specific and unusual. For a relatively brief period, the Romans occasionally built hospitals (*valetudinaria*) for slaves and soldiers—the two categories of laborers who mattered most to the functioning of the empire. Slave hospitals were favored by many wealthy owners from the first century B.C. to the end of the first C.E. When the supply of slaves from conquest had diminished, and prices had risen, those who could work and breed became well worth maintaining. When the empire's crucial labor force became the *coloni*, living in quasi-peasant households, slave hospitals were no longer economical or necessary.²⁰

The rise and fall of military hospitals came a little later—from the time of Augustus to the mid-third century C.E.—but is explicable in similar structural-cum-economic terms. During that period, the army often operated well beyond the empire's northern frontiers, in areas largely bereft of friendly settlements where sick and wounded soldiers could recuperate. In the third century, the army was reorganized, and a local militia, supported by a mobile field army, defended the frontier, thus rendering the construction of fortress hospitals unnecessary. Thereafter, sick soldiers fell to the care of their families or remained in their own tents—just as sick *coloni* were tended by their wives or relatives. The age of Roman hospitals was over.

Even at its height, neither kind of hospital was widespread. The second-century Roman writer now known as pseudo-Hyginus included a hospital in his description of the standard Roman tented camp. Yet such hospitals under canvas may not have been any more common than the permanent fortress type. Further literary evidence for them is lacking. Moreover, the archaeological record of military hospitals of any kind is now even slighter than ever, because the identification of a number of proposed sites of *valetudinaria* is now being questioned. Even less is known about the number and distribution of slave hospitals. Occupying a highly

20 Georg Harig, "Zum Problem 'Krankenhaus' in der Antike," *Klio*, LIII (1971), 188–193; Nutton, "Healers in the Medical Market Place: Towards a Social History of Graeco-Roman Medicine," in Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge, 1992), 50–52; Nutton, "Hospitals in Antiquity," unpub. paper (London, 1985); Leonhard Schumacher, *Sklaverei in der Antike: Alltag und Schicksal der Unfreien* (München, 2001); Jonathan P. Roth, *The Logistics of the Roman Army at War (264 B.C.–A.D. 235)* (Leiden, 1999), 86.

specific “niche” in Roman history, they reflect a calculation of the economies of scale to be made by the centralized reconstituting of the workforce. Such a calculation would not occur again until the later Middle Ages in Italy, when hospitals once again attempted a rapid patient turnover.²¹

No one in the mid-fourth century is likely to have seen the buildings that were formerly *valetudinaria* (if the structures survived at all), and hardly anyone to have read or heard about them. The Christian hospital of the fourth century was essentially a new creation in European, Mediterranean, or Middle Eastern history.

EARLY JEWISH HOSPITALS Another way of looking at this phenomenon that might account for the gaps in the line of transmission of the hospital idea, as well as the apparent lack of a “pre-history” of this sudden invention, derives from Jewish hospitals. The assertion that no hospitals except the Roman *valetudinaria* existed in the ancient world before the Christian foundations of the reign of Constantius II is a slight exaggeration: “Theodotos, son of Vettenos the priest and synagogue leader [*archisynagogos*] . . . built the synagogue . . . and a hostel with chambers and water installations for the accommodation of those who, coming from abroad, have need of it.” So runs a well-known inscription from first-century Jerusalem. Some have wanted to claim it as the first Jewish hospital of a medical kind, even though there is no reason to think that doctors attended those staying in it.²²

Several paradoxical aspects of the establishment should be stressed. First, as a “hostel with chambers,” it resembles the accommodation for visitors beside any major shrine in the ancient world, such as that of Epidaurus. Until its destruction in 70 C.E., the Temple in Jerusalem was perhaps the largest temple of its time, and virtually the sole focus of Jewish pilgrimage. It doubtless attracted far more visitors than did most pagan shrines, which would come fully to life only at festivals once or twice a year. It presum-

21 Patricia Anne Baker, “The Roman Military *Valetudinaria*: Fact or Fiction?,” in Robert Arnott (ed.), *The Archaeology of Medicine* (Oxford, 2002), 69–80. Hyginus, *Liber de Munitioibus Castrorum*, 4, in M. C. M. Miller and J. G. DeVoto (trans. and eds.), *Polybius and Pseudo-Hyginus: The Fortification of the Roman Camp* (Chicago, 1994), 68–69. For the later Middle Ages, see John Henderson, *The Renaissance Hospital* (forthcoming).

22 Théodore Reinach, “L’inscription de Théodotos,” *Revue des études juives*, LXXI (1920), 46–56. The translation is quoted from Steven Fine (ed.), *Sacred Realm: The Emergence of the Synagogue in the Ancient World* (New York, 1996), 9.

ably offered its facilities in a more charitable spirit than the pagan ones did. That a Jerusalem synagogue of the first century C.E. should have catered to needy visitors is hardly surprising. Second, in the surprising apparent absence of any wider system of organized charity in Jerusalem at the time, individual initiatives such as that of Theodotos were crucial. Third, little or no archaeological, epigraphic, or textual evidence records any other such hospices attached to synagogues in the first five or six centuries C.E., despite a number of rabbinical texts suggesting that travelers lodged within a synagogue precinct.²³

The first distinct reference to Jewish hospitals appears in a letter of 598 of Pope Gregory the Great about the Christian appropriation of synagogues and their guesthouses in Palermo. In the mid-fourth century, the pagan emperor Julian had paid Jewish and Christian philanthropy the compliment of imitation, ordering hospitals to be established, because “it is disgraceful that, when no Jew ever has to beg, and the impious Galileans [i.e. Christians] support not only their own poor but ours as well, all men see that our people lack aid from us.” We should not read too much into the distinction that he draws between Jews and Christians. Yet it is still notable that he associates Christians with the generalized support for the poor that would be manifested, *inter alia*, in hospitals, and the Jews with the relief of potential beggars. The Jews’ form of relief is at least consistent with an absence of indoor, hospital care and with an emphasis on outdoor distribution (for example, the characteristic *quppah*, the weekly dole to resident poor, or the soup kitchen that may have been part of the synagogue at Aphrodisias). The paradox of the Jerusalem hostel is that it blends far better into a pagan than a Jewish context, looking forward to

23 Context is discussed by Nutton, “Hospitals in Antiquity”; *idem*, “From Galen to Alexander,” 9. Unlike others, I remain persuaded by the negative answer defended by David Seccombe in “Was There Organized Charity in Jerusalem before the Christians?” *Journal of Theological Studies*, XXIX (1978), 140–143. On the minimal and ambiguous evidence of other synagogue hostels, see Carl H. Kraeling, *The Synagogue: The Excavations at Dura-Europos Final Report VIII, Part I* (New Haven, 1979; orig. pub. 1956), 10–11. The only recent discussion known to me is Frank M. Loewenberg, *From Charity to Social Justice: The Emergence of Communal Institutions for the Support of the Poor in Ancient Judaism* (New Brunswick, 2001), 141–142, 153. On synagogue hospitality, see also S. Safrai and M. Stern (eds.), *The Jewish People in the First Century: Historical Geography, Political History, Social, Cultural and Religious Life and Institutions* (Amsterdam, 1976), II, 943; Lee I. Levine, *The Ancient Synagogue: The First Thousand Years* (New Haven, 2000), 381–382.

Christian hospitals of almost three centuries later rather than standing in a demonstrable tradition of its own.²⁴

This paradox seems only compounded by evidence from subsequent periods. In the later Middle Ages, Jewish hospitals were widespread—probably following the Christian example—in those parts of Europe where Jews were tolerated. These hospitals were often referred to as *hekdeshim*; but the *hekdesh*, “the holy,” comprised more broadly the property and assets of the community. There was no more specific designation for Jewish hospitals. Earlier, in the tenth to thirteenth centuries—the gaonic period illuminated by the archive of the Geniza of old Cairo—similar ambiguities prevail. The city apparently had only one major hospital—a hospital with doctors. It was a Muslim foundation; the city’s Jewish population had nothing like it, at least so far as the Geniza reports. Nor does it refer to Jews as patients in the Muslim hospital, even though some of that hospital’s physicians would have been Jewish. Whether Jews ever in fact placed themselves in the hands of the Muslim foundation, overcoming the dietary problem by having friends or relatives supply their food, is a matter for conjecture. Any impoverished Jew who needed sustained nursing or medical attention was much more likely to have received it in the home or in the doctor’s surgery. As for transients, they might be put up in a *funduq* (an Arabic word meaning caravansary, but derived from the Greek *pandocheion* or inn, which is close to the Christian term for a hospital, *xenodocheion*). Equally, needy guests might take vacant rooms within houses that were part of the synagogue’s endowment or set aside ad hoc within the synagogue.²⁵

24 For hospitals in the letter by Gregory the Great, see *Register*, 9.38, in M. Hartmann (ed.), *Gregorii I Papae registrum epistolarum* (Berlin, 1899), II, 67. For Julian’s *Letter 22* to the high priest of the province of Galatia, see Wilmer Cave Wright (ed. and trans.), *The Works of the Emperor Julian* (London, 1953), III, 70–71. On the controversial “soup kitchen,” see Joyce Reynolds and Robert Tannenbaum, *Jews and Godfearers at Aphrodisias* (Cambridge, 1987), 28–29, 41.

25 I do not know of a satisfactory modern study of Jewish hospitals in the later Middle Ages. See Mark Cohen’s section on medical care for the needy in *Poverty and Charity in the Jewish Community of Medieval Egypt* (forthcoming). The fundamental study remains Shelomo Dov Goitein, *A Mediterranean Society: The Jewish Communities of the Arab World as Portrayed in the Documents of the Cairo Geniza* (Berkeley, 1977–1988), 5v. For the case at hand, see *ibid.*, II, 113–114, 133, 135–136, 153–154, 251. For the *funduq*, see Olivia Remie Constable, *Housing*

The contrast between this type of establishment and the Christian xenodocheion is marked, and diagnostic. To oversimplify, the Christian xenodocheion packed an ideological punch out of all proportion to its size and distribution. Even with Brown's account of its symbolic weight qualified, it is still a deliberate reminder of the established Christian Church's affront to ancient civic values. The Jewish hostel within, or adjacent to, the medieval synagogue complex seems to have been its converse; it is a hospital with a history difficult to write precisely because substance outweighs symbolism. Unlike the Christian xenodocheion or nosokomeion, it had no specific name. Nor was it a means to social revolution, but, rather, a quick and unobtrusive adjunct to the range of social services by which Jewish communities tried to protect their more valuable new arrivals from the shame of poverty.

The Geniza evidence also suggests that the synagogue hekdesch cannot be viewed in isolation from other hospitals or quasi-hospitals scattered across the Jewish households of the city. The Jewish hospice—a room in the synagogue complex, a room in a building otherwise rented commercially, a room in a private household for which the synagogue paid rent—seems to present a uniform picture rather than to represent divergent and unequal possibilities. Nor was the synagogue the only provider of such indoor support. A twelfth-century Jewish judge in old Cairo, for instance, kept a private hospice for the sick and elderly within his home.²⁶

These examples suggest a point of wider application. The best-documented hospitals were not only ideological inventions that, in any given culture or century, either exist or do not exist; important forms of charity also lay “behind” the ideology, in the less formal, or less permanent, establishments that comprise the hinterland of hospitals and help to explain their appearance. Hospital historians have characteristically tried to determine when, and in what circumstances, hospices for the poor became “true” hospitals for the sick—truth being defined (inappropriately) by the documented attendance of doctors. But the emergence of hospi-

the Stranger in the Mediterranean World: Lodging, Trade, and Travel in Late Antiquity and the Middle Ages (Cambridge, 2003), 85–88.

26 Goitein, *Mediterranean Society*, II, 251–252.

tals is less a matter of personnel than of structure, or morphology. The hospital was a solidification—architectural or ideological—of part of the spectrum of “sub-hospitals,” not always independent structures but fulfilling many, or all, of the functions of premodern hospitals: converted parts of a house or villa (as like those of Fabiola in late fourth-century Rome or the judge in twelfth-century Cairo); covered porticos or atriums of churches; temporary shelters in times of famine; or even derelict buildings appropriated by paupers—foundations from below. The list might include some of those locations in which ancient historians have searched diligently for pagan hospitals to show that neither Jews nor Christians “got there first”—the area around healing shrines in which the sick “incubators” might by day need some basic care (even if they lodged elsewhere at night), or the small *iatreion* in which a doctor lodged patients. The analysis can embrace such locations on a spectrum of more or less hospital-like facilities because it treats the xenodocheion and its successors as simply a higher-order part of that spectrum.²⁷

Hospital history of this more inclusive kind complements the ideological history of invention and diffusion. It helps to explain some of the gaps in that history. The bishop’s house is likely to have been the matrix of mid-fourth-century hospitals in Byzantium, or fifth- to sixth-century hospitals in Gaul. The change of style in poor relief from rooms in the bishop’s house or its surrounding outbuildings to conceptually or architecturally free-standing hospitals might have been slight indeed. Augustine’s complex at Hippo in the early fifth century had 120 rooms—plenty of scope for a de facto xenodochium, even though Hippo’s first Christian hospital foundation was the work of another priest. When they emerged, synagogue hospices probably related to their surroundings in a similar way. In the Islamic world, the change was a matter of initiative. Where once Christians did the found-

27 For an argument that true hospitals require physicians, see Miller, *Birth*. For a hospital in a Spanish villa, see Brown, *Poverty*, 130, n. 22. For Paulinus of Nola and a portico hospital in the early fifth century, see Paulinus, *Poem* 21, ll. 384–386, in P. G. Walsh (trans.), *The Poems of St. Paulinus of Nola* (New York, 1975), 185. I infer the general possibility of foundation from below from Max Satchell, “The Emergence of Leper Houses in Medieval England, 1100–1250,” unpub. D.Phil. thesis (University of Oxford, 1998). For temporary hospitals and famine relief, see Palladius, *Historia Lausiaca*, 40, in Cuthbert Butler (ed.), *The Lausiaca History of Palladius* (Cambridge, 1904), II, 126–127. For pagan quasi-hospitals, see Nutton, “Hospitals in Antiquity”; Harig, “Zum Problem ‘Krankenhaus.’”

ing, Islamic elites began to do so, perhaps as an implementation of a newly received Galenic medical program.²⁸

WERE HOSPITALS IRRELEVANT? Removing some of the gaps in this way raises in a slightly altered form the question of what difference hospitals made. The answer thus far is twofold. The first part is ideological. Hospitals had symbolic potency in eastern Mediterranean cities of the mid-300s. For that reason, they can be interpreted as an invention that was, with interruptions, transmitted both eastward and westward for centuries. Their adoption testifies to the difference that they were thought to make.

The second part of the answer is more materialist. “Hospitals” were an intensification or solidification of one part of a blurred spectrum of hospital-like provisions. From this perspective, hospitals might not have made so much of a difference. The transition from background noise to the clearer signal of named hospitals could have entailed no more than a modest increase in visibility. The visibility might have attracted greater charity, and hence led to an increase in size. Such a change was not, however, necessarily inherent in the emergence of the xenodocheion into the light of the surviving evidence.

Any contention that hospitals made no difference at all, however, would betray a supply-side history that focuses exclusively on founders, their attitudes, and the “raw materials” (the sub-hospitals) with which they sometimes operated. What is needed to round out the picture is a demand-side account, which looks at the impact of hospitals on the poor. Such an account might seem unpromising. It is not hard to portray early hospitals as making little difference to the ranks of the impoverished.

Many, if not most, late-antique and early-medieval hospitals were small. Hospitals with 200 beds are much the exception, confined to Constantinople or such major pilgrimage centers as Jerusalem, within the sphere of influence of major founders like the emperor Justinian. Overall, even in large foundations, beds usually numbered in the tens, not the hundreds; doubling the

28 For the bishop’s house, see Sternberg, *Orientalium More Secutus*, 52–92. Augustine, *Sermon* 356.10, in Jacques-Paul Migne (ed.), *Patrologia Latina* (Paris 1844–1865), XXXIX, col. 1578; Brown, *The Rise of Western Christendom* (Oxford, 2003; orig. pub. 1996), 78; *idem*, *Poverty*, 65.

numbers of beds to match the number of inmates (who often slept two to a bed) still does not produce impressive totals.²⁹

Early hospitals apparently were not numerous either. Counting them began in 1680 when Du Cange published *Constantinopolis Christiana*, listing thirty-five charitable institutions. Janin's more recent tabulation for the capital—not wholly reliable—included thirty-one xenones and hospitals and twenty-seven old people's homes. The most recent survey for the provinces of the Byzantine empire, up to the mid-ninth century, gives a total of more than 160 charitable facilities of various kinds, of which the most numerous are xenodocheia and xenones (71), nosokomeia (44), and *ptocheia* (poorhouses; 21). No modern and comprehensive surveys cover Italy or Spain (only one Spanish institution is discussed, though others have left traces). The textual and archaeological deposit of Merovingian Gaul shows signs of only thirty-four hospitals, the majority in the northeast of the country. Jewish hospitals of the early Middle Ages are too elusive for the statistician. As for Islam, the statement that "a hospital was an essential feature of any large Islamic town" applies only to the twelfth century and thereafter. No genuinely comprehensive survey of the evidence is available, but only ten or eleven hospital foundations are attested before the year 1000 C.E. Seven of them were in Baghdad, three in Iran, and one seemingly in old Cairo. Only from the eleventh century onward did the Islamic "hospital idea" spread to Mesopotamia and Syria, and westward around the southern Mediterranean.³⁰

Two further comparative points are possible. First, not only do the figures for size support the view that early medieval hospitals were small in comparison with, say, early modern ones; the

29 Nutton, *Ancient Medicine* (London, 2004), 307–308; Constantelos, *Byzantine Philanthropy*, 122. For a multi-storied hospital, see Miller, "The Sampson Hospital of Constantinople," *Byzantinische Forschungen*, XV (1990), 113.

30 Charles du Fresne du Cange, *Historia Byzantina. II. Constantinopolis Christiana* (Paris, 1680), 163–166; Robert Janin, *La géographie ecclésiastique de l'empire byzantin, première partie. III. Les églises et les monastères* (Paris, 1969; orig. pub. 1953), 552–567; Konstantina Mentzou-Meimare, "Eparchiaka evage idrymata mechri tou telous tes eikonomachias," *Byzantina*, XI (1982), 243–308; Sternberg, *Orientalium More Secutus*, 291 (map); Walther Schönfeld, "Die Xenodochien in Italien und Frankreich im frühen Mittelalter," *Zeitschrift der Savigny-Stiftung für Rechtsgeschichte, Kanonistische Abteilung*, XII (1922), 1–54; Conrad, "Arab-Islamic Medicine," in William F. Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine* (London, 1993), II, 716; *idem*, "Institution of the Hospital."

figures for their total number are small even by comparison with later periods within the Middle Ages. For example, the almost 300 hospitals for lepers alone that were founded in England between 1100 and 1250 comfortably exceed current estimates for the whole Byzantine empire over a much longer period. Second, whether measured by average size or total number, the scale of hospital provision paled relative to other sources of social welfare. In late antiquity, the *annona* (dole) of grain and other foodstuffs in Rome, Constantinople, and even such small towns as Oxyrhynchus reached a far larger number of poor people than any estimate of the total hospital population. Hospital capacity was not only dwarfed by such state-run measures. It was probably, in aggregate, surpassed even by the Church's own "outdoor" distributions to its local poor—those whose names were inscribed, sometimes by the thousand, on registers of the deserving.³¹

This "minimalist" interpretation is strengthened by the large blanks that remain on the map. There are no clearly recorded hospitals in Celtic Ireland or Anglo-Saxon Britain before their respective Norman conquests, other than monastic infirmaries (run by monks for sick brethren). Much the same can be said of the Scandinavian world during the early Middle Ages (despite the anecdote presented below). The East Frankish lands and Eastern Europe generally present another great void, though with such notable exceptions as Erembert's hospital at Bremen. West Frankish lands notwithstanding, the map becomes relatively crowded only to the south and east around the Mediterranean.³²

Some of the explanations for the fourth-century proliferation of hospitals devised by modern historians play down the difference that they might have made. For example, if the hospital building

31 Satchell, "Emergence of Leper Houses;" Brown, *Poverty*, 27–28, 65; Judith Herrin, "Ideals of Charity, Realities of Welfare: The Philanthropic Activity of the Byzantine Church," in Rosemary Morris (ed.), *Church and People in Byzantium* (Birmingham, 1991), 153–154; Peter Garnsey and Caroline Humfress, *The Evolution of the Late Antique World* (Cambridge, 2001), 126–127.

32 Wendy Davies, "The Place of Healing in Early Irish Society," in Donnchadh Ó Corráin, Liam Breatnach, and Kim McCone (eds.), *Sages, Saints and Storytellers: Celtic Studies in Honour of Professor James Carney* (Maynooth, 1989), 43, notes the absence of "any strong tradition of sick care in early Irish monastic rules." On Anglo-Saxon hospitals, see most recently Audrey Meaney, "The Practice of Medicine in England about the Year 1000," *Social History of Medicine*, XIII (2000), 224–227. For the Bremen hospital, see Rimbert, *Vita S. Anskarii*, 35, in Werner Trillmich (ed.), *Quellen des 9. und 11. Jahrhunderts zur Geschichte der Hamburgische Kirche und des Reiches* (Darmstadt, 1978), 112.

in Caesarea and elsewhere were a response to a population boom posited in the fourth-century eastern empire that generated substantial migration to the cities, it must have been an inadequate one. However, without the support of such a boom, which seems increasingly unlikely from new interpretations of the archaeology and the texts, the earliest hospitals are left without any *raison d'être*—at least, one describable in simple economic and demographic terms.³³

In general, it seems, periods of intense hospital foundation correlate poorly with big trends in population or the economy. The foundations of the fourth to fifth century around the Mediterranean mesh well not with Malthusian crisis in the countryside but with sustained growth and prosperity, which should have reduced the number of unemployed migrants and increased the number and wherewithal of potential founders. The economic expansion of twelfth-century Europe saw another phase of hospital construction, the most intense until the Renaissance. Otherwise, the establishments of Italy, Gaul, or Spain in the first half of the Middle Ages can hardly be said to reflect economic changes, whether toward growth or contraction. Moreover, the hospitals of early Abbasid Islam mirror more closely the intellectual and religious environment than the character of the caliphate's economy, which had already prospered for some time.³⁴

Were hospitals then irrelevant during the early Middle Ages? Did they make no difference to the poor because, overall, the history of poor relief (hospitals included) must be understood more in terms of the founders' ideology than of the history of poverty? The failure of economic history to explain changes in hospital history does not mean that economics made no difference to founders' attitudes. In some areas, the poor may have been too few to prompt the concentration of services embodied in a hospital—as

33 Patlagean, "Poor," 18. Brown, *Poverty*, 128, n. 13, gives some more recent bibliography on the prosperity of the later Roman Empire in the east. See also Jairus Banaji, *Agrarian Change in Late Antiquity: Gold, Labour, and Aristocratic Dominance* (Oxford, 2001), 214–215; Peter Sarris, "Rehabilitating the Great Estate: Aristocratic Property and Economic Growth in the Late Antique East," in William Bowden, Luke Lavan, and Carlos Machado (eds.), *Recent Research on the Late Antique Countryside* (Leiden, 2004), 55–71.

34 I shall not try to buttress that brief overview. Some of the issues raised appear in Horden and Nicholas Purcell, *The Corrupting Sea: A Study of Mediterranean History* (Oxford, 2000), 153–172. See also Michael McCormick, *Origins of the European Economy: Communications and Commerce AD 300–900* (Cambridge, 2001).

was increasingly the case to the north and west, thereby accounting for some of the blank spaces on the early medieval map. In many more areas, the “perceived need”—the result of filtering out the undeserving, disreputable poor—may have been small. A strangely persistent historiographical myth is that charity was indiscriminating before the twelfth century or, in some accounts, the Reformation. The widespread lists (*matriculae*) of the local poor supported by the Church is sufficient testimony to discrimination; genuinely open-handed, unquestioning distributions were rare.

A story in Rimbert’s *Life* of Anskar, the ninth-century “apostle of the north,” may illustrate both the genuine absence of poverty and the blinkered perception of need. A wealthy and pious lady of Birka on Lake Mälaren, Sweden, instructed her daughter to distribute all her mother’s possessions to the poor after her death. Since her immediate area had few poor, the daughter was to go to the much larger emporium at Dorestad, which had a multitude of clergy and paupers. When the time came, devout women of Dorestad took her to the local churches and apparently selected for her those to whom she should give alms. Although Rimbert wrote shortly after his subject’s death, his background details are fanciful: The archaeology of Dorestad reveals wharves and warehouses, not churches. Clearly, however, he reckoned that a geography of poverty in which areas of “scarcity” coexisted with areas of “abundance” (the latter associated with churches) would be entirely plausible to his audience. The important point is that the selectivity in almsgiving that he implicitly portrays has the effect of scaling down the acknowledged demand for all forms of ecclesiastical charity—the sub-hospital of the bishop’s house, the *matricula*, as well as the hospital.³⁵

THE DEFENSE OF HOSPITALS Given the above defense of the proposition that hospitals made little detectable difference socially or

35 Rimbert, *Vita S. Anskarii*, 20, in Trillmich (ed.), *Quellen*, 35; Ian Wood, *The Missionary Life: Saints and the Evangelisation of Europe 400–1050* (Harlow, 2001), 123–132. For the lesser scale of poverty in Western Europe, as compared with Byzantium, see Brown, *The Cult of the Saints: Its Rise and Function in Latin Christianity* (London, 1981), 40, although Brown, *Poverty*, which takes a different view of the scale of poverty in the east, would presumably downplay his earlier stark contrast. For context, see Valerio Neri, *I marginali nell’occidente tardoantico: poveri, “infames” e criminali nella nascente società cristiana* (Bari, 1998), 97–102, the latest contribution to the literature on the *matricula pauperum* in Gaul.

economically to the poor, what can be said in a more positive spirit?

First, even in the historiography of the infinitely better-documented nineteenth century, the general impact of institutional charity remains hard to assess. Was charity ever a regular source of income for the poor, or was formal relief totally inadequate? Did charity exercise a negative or a positive influence on the wider economy? The debate continues. The ambiguity of earlier and more obscure periods need not be daunting. Lack of evidence does not by itself settle the issue of whether hospitals had any impact other than on the otherworldly prospects of their founders.³⁶

Second, thanks to imperial patronage, the new establishments of the fourth century onward could well have represented a massive increase in the scope of formal ecclesiastical charity by comparison with that of the pre-Constantinian centuries. Spectacular feats of routine organization took place before c. 300 (as in third-century Rome), including impressive episcopal initiatives in times of crisis (especially famine). Yet such projects were likely to have stood in high relief against a duller background of small-scale and introverted philanthropy. The local distributions, sick visiting, and (often strictly limited) hospitality to transients of the Pauline communities and their successors throughout the next century probably did not amount to much in aggregate. In *Mission and Expansion of Christianity in the First Three Centuries*, Harnack emphasized open-handed charity as a primary factor in Christianity's success. More recently, Stark and others have offered similar analyses. But it is not clear that the size of the Christian population on the eve of Constantine's conversion was large enough to justify a special explanation of this kind, or that charity was a more potent factor in conversion and diffusion than, say, charismatic healing.³⁷

Third, hospitals could achieve considerable density in certain

³⁶ van Leeuwen, *Logic of Charity*, 20, 26.

³⁷ Garnsey and Humfress, *Evolution*, 123–127; Brown, *Poverty*, 17, 27; Adolf von Harnack, *Mission und Ausbreitung des Christentums* (Leipzig, 1924; orig. pub. New York, 1904/5 [trans. J. Moffat]). See also Rodney Stark, *The Rise of Christianity: A Sociologist Reconsiders History* (Princeton, 1996), and his papers as discussed in William R. Garrett, "Sociology and New Testament Studies: A Critical Evaluation of Rodney Stark's Contribution," *Journal for the Scientific Study of Religion*, XXIX (1990), 377–384; Gary B. Ferngren, "Early Christianity as a Religion of Healing," *Bulletin of the History of Medicine*, LXI (1992), 1–15; MacMullen, *Christianizing*, 25–42; Robert M. Grant, *Early Christianity and Society* (London, 1977), 124–145.

areas, despite the modest aggregates presumed above. Medievalists studying later centuries often find estimates of total hospitals to be, on closer archival inspection, much too low, even if many institutions were ephemeral. For instance, one recent study of later medieval to post-Reformation East Anglia in England doubled the number of known philanthropic foundations. Similarly, traces of more and more local hospitals turn up in the papyri recovered from the rubbish tips of late antique Egypt. As in Gaul and elsewhere, they clustered, in this case in Middle Egypt. Hermopolis seems to have had at least eight nosokomeia (specifically for the sick) and several other xenodocheia—a generous provision in a conurbation of 40,000 at most. Hospitals of varying sorts could also be found in relatively small villages. The patient turnover might be considerable. In Alexandria, John the Almsgiver established seven forty-bed hospitals for post-parturition women. If the women each stayed for a week (as prescribed), the bishop could have facilitated more than 14,000 births a year. Gregory Nazianzen called the hospital a stairway to heaven, implying that it aimed only to ease death for the chronically or terminally ill rather than promote recovery. But later comparative evidence suggests that hospitals were not always “the end of the road,” and some anecdotes imply that, for example, Byzantine hospitals worked to cure acute cases.³⁸

Fourth, the economic and social “difference” that hospitals could make need not be confined to the effects upon inmates. Hospitals were sources of employment for priests, doctors (sometimes), nurses, attendants, gravediggers (if less often than has been imagined), builders, and maintenance staff of all kinds—many of whom will have been as poor as the inmates. A collectivity of small hospitals could markedly have increased local opportunities in a world characterized by chronic underemployment.³⁹

38 Elaine Phillips, “Charitable Institutions in Norfolk and Suffolk,” unpub. Ph.D. diss. (University of East Anglia, 2001); Peter van Minnen, “Medical Care in Late Antiquity,” in Philip J. van der Eijk, H. F. J. Horstmanshoff, and P. H. Schrijvers (eds.), *Ancient Medicine in Its Socio-Cultural Context* (Atlanta, 1995), I, 153–169. For John the Almsgiver, see *Life*, 7, in Elizabeth Dawes and Norman Baynes (trans.), *Three Byzantine Saints* (Oxford, 1948), 203. Gregory Nazianzen, *Oratio*, 43.63. In the tenth-century (?) *Life* of Luke the Stylite, a patient with severe head injuries is discharged as incurable from one major Constantinople xenon to end his days in some other unnamed institution (Hippolyte Delehayé [ed.], *Les saints stylites* [Paris, 1923], 218).

39 On hospitals as sources of employment, see Patlagean, *Pauvreté*, 196–203; Rawcliffe, *Medicine for the Soul*.

Fifth, hospitals also reached beyond their walls in their services. Their functions sometimes (perhaps often) elided with those of “outdoor” relief centers—soup kitchens, bathing facilities for the poor, charitable grain stores and so forth.⁴⁰

Finally, contemporary reports suggest that hospitals had a significant effect on the poor. The emperor Julian thought that “pagan” hospitals were well worth establishing. In the Christian Armenia of the 350s, the decade in which the Christian hospital emerged in Byzantium, the Patriarch Nerses established a network of hospitals to keep beggars off the streets. When King Pap, the patriarch’s enemy, jealously destroyed them, the poor returned to beggary throughout the kingdom. The patriarch’s hospitals were represented (admittedly more than a century after they were built) as all-embracing.⁴¹

THE DEMAND FOR BEDS What would have been the effect of a similar mass closure in Byzantium c. 450, of Frankish hospitals in 650, or of Islamic hospitals c. 1200? The answer partly depends on the effective demand for hospital places, which is not by any means necessarily coincident with the demand perceived by registrars of the poor, who tended to look down on the “laboring poor” with large families in favor of the more Biblically sanctioned widows, orphans, and the sick. This effective demand must have varied markedly from area to area, even if, overall, it diminished on a line from the Middle East to northwestern Europe.⁴²

Demand for hospital beds has often been measured in relation to estimates of total population or of the likely number of the poor and sick in the society in question. Hospitals often fare poorly on this basis because they could seldom have accommodated the 10 percent of the population in absolute penury, let alone the extra

40 For a hospital’s distributions, see Bernard P. Grenfell and Arthur S. Hunt (eds.), *The Amherst Papyri* (London, 1901), II, 188–189, no. 154; Nicholas Orme and Margaret Webster, *The English Hospital 1070–1570* (New Haven, 1995), 49–68.

41 For Julian, see Wright (ed. and trans.), *Works*, III, 70–71. For Armenia, see Garsoian (trans.), *Epic Histories*, 211–212; Brown, *Poverty*, 42–43.

42 Fuller documentation of what follows can be found in Horden, “A Discipline of Relevance: The Historiography of the Later Medieval Hospital,” *Social History of Medicine*, I (1988), 359–374; *idem*, “Household Care and Informal Networks: Comparisons and Continuities from Antiquity to the Present,” in *idem* and Richard Smith (eds.), *The Locus of Care: Families, Communities, Institutions and the Provision of Welfare since Antiquity* (New York, 1998), 21–67; *idem*, “Family History and Hospital History in the Middle Ages,” in Eugenio Sonnino (ed.), *Living in the City* (Rome, 2004), 255–282.

20 to 30 percent who might need relief at some point. But the massed ranks of the poor are only the potential demand. The effective demand would have been significantly less, because of self-help and other sources of charity than hospitals.

Self-help and alternative sources of aid are easier to imagine than to describe in detail. The proportion of contributions from “vertical” relief—aid from the state, the Church, and individual benefactors—is impossible even to estimate for any part of the period at hand. Moreover, the history of poor relief is much wider than the history of charity. Unlikely topics come into play: the minimal care of sick slaves provided by owners (outside the few *valetudinaria*), the grim institution of debt bondage, rural patronage, benefactions to citizens from local pagan aristocrats (who had no concept of charity), distributions organized by temples, etc.

In this context, to ask what difference hospitals made is scarcely worthwhile. The hospital contribution cannot be separated from the vertical component of poor relief. Nor did the establishment of Christianity and the proliferation of charitable institutions from the fourth century onward necessarily mark a decisive change in the relative strength of the vertical component, separating classical from late antiquity or the ancient from the medieval world. Charity may not have been a virtue in ancient pagan society, but poor relief could have been practiced directly or indirectly—to an extent that is now wholly obscure.⁴³

A wide comparative survey warns that the strength or capacity of the “horizontal” component in relief—self-help and mutual aid among social equals—should not be overestimated. The large supportive households to which historians have blithely attributed the overwhelming bulk of premodern support for the poor are hardly ever to be found. Pauper households were small, and vulnerable to “nuclear hardship.” Networks of support, which were more liable to operate between them than within them, were fragile and limited. They needed vertical buttressing if their beneficiaries were to avoid sinking into criminality or terminal destitution.⁴⁴

43 Brown, *Persuasion*, 92–93. Nutton, “From Galen to Alexander,” 10, hypothesizes a crisis of patronage during the third to fourth centuries that could help explain the rise of the hospital in the later Roman Empire. I do not know how such a crisis could readily be detectable.

44 For the comparative bibliography, see Horden, “Household Care”; Adriann Verhulst, *The Carolingian Economy* (Cambridge, 2002), 23–28, on the early medieval western peasant family; Neri, *Marginali*.

The best evidence of this weakness is “high” medieval—the Cairo Geniza or the Miracles of Saint Louis in Farmer’s analysis. Specifically late antique or early medieval evidence on this score is hard to find. General exhortations to neighborliness are in evidence but few representations of the poor in groups, other than as faceless beggars or criminal gangs. Early medieval Western hagiography is the least unhelpful type of source. Isolated vignettes show the extent of neighborly and familial assistance in certain Dark Age texts not hitherto exploited in this context, such as the aforementioned Anskar’s *Miracles* of St. Willehad. But the most ample illustrations lie in the corpus of hagiographies written by Gregory, bishop of Tours, during the later sixth century, in which pauper households appear predictably small and mostly conjugal. Neither the immediate family nor the wider kin group is depicted as supportive. Instead, a resort to institutional or informal charity seems commonplace.⁴⁵

As an example in one of Gregory’s miracle narratives, “a woman named Foedamia was restricted by swelling due to paralysis and felt pain whenever she moved any part of her body. Her relatives brought her and put her on display at the blessed church [of St. Julian in Brioude], so that she might earn her keep from almsgivers.” When the martyr Julian appeared to her, she was cured. Gregory does not reveal how old Foedamia was, but he states that she had been paralyzed for eighteen years. Her relatives were not guilty of ridding themselves too hastily of the burden of an unproductive family member, presumably in need of continual nursing. Nonetheless, Gregory’s casual and nonjudgmental report of their decision to put the woman out to beg is striking.⁴⁶

In another story, from the *Miracles* of St. Martin of Tours, Gregory offers an excuse for a similar familial response to incapacity. A blind child was “given to beggars, so that he might wander about with them and receive some alms; for his parents were very

45 For a sample of the Geniza material, see Goitein, *Mediterranean Society*, II, 460; V, 74, 110, 117, 122. I take a view of this evidence different from that of Mark Cohen, to whom I am indebted for discussion and references. See Cohen, *Poverty and Charity in the Jewish Community of Medieval Egypt*. For the miracles of St. Louis, see Sharon Farmer, *Surviving Poverty in Medieval Paris: Gender, Ideology and the Daily Lives of the Poor* (Ithaca, 2002). Note also William Chester Jordan, *Women and Credit in Pre-Industrial and Developing Societies* (Philadelphia, 1993), too little known in this context. *Miracula S. Willehadi auctore S. Anskari episcopo Bremensi*, IX, XII, in *Acta Sanctorum*, November, III, 349. Wood, *Missionary Life*.

46 Gregory, *De virtutibus Juliani*, IX, in Raymond Van Dam (trans.), *Saints and Their Miracles in Late Antique Gaul* (Princeton, 1993), 170.

poor.” Elsewhere in Gregory’s writings, neighborly support is represented as somewhat out of the ordinary. A slave named Veranus, stricken with gout, lost the use of his feet. “After Veranus was afflicted for an entire year with such pains that even his neighbors located nearby carried him [*ut etiam vicina in proximo posita commoveret*], suddenly his nerves stiffened and he was completely crippled.” Hence, his master, “grieved at the loss of a faithful slave” (or the loss of his labor), had him brought to the shrine of St. Martin.⁴⁷

These stories focus on healing shrines, not on an institution of poor relief in the usual sense. Like much of the evidence of informal, “horizontal” poor relief, they are skewed toward failure, showing networks of support only at the moment of breakdown. Yet, Gregory’s narratives reveal how an early medieval hagiographer recorded, or imagined, the prior biographies of those who benefited at his favored shrines. He had no reason to filter larger support groups out of his narrative if he actually encountered them—that is, no pastoral or theological imperative to represent only the nuclear family. If horizontal poor relief was relatively weak in the early Middle Ages (as it seems to have been in later and better-documented periods), the estimate of the aggregate burden on the vertical kind should be correspondingly increased, thereby giving greater emphasis to the role of hospitals. The argument can be pressed no further.

HOSPITAL MEDICINE Left until last is the subject that many hospital historians would have put first, medicine. Van Minnen wondered why such a “major revolution . . . in medical care” as the hospital seems to have had no discernible impact on the medical literature of late antiquity. According to Miller, Byzantine hospitals, like later Islamic ones but unlike their contemporary Western European counterparts, were centers of medical excellence, staffed by the leading physicians of the time; of medical education; and of medical learning, with libraries and scriptoria. These claims are largely unfounded. Byzantine hospitals were indeed a new source of medical care in the fourth century; valetudinaria could not have matched them in this respect. But the medicine of these hospitals was, to judge by surviving manuscripts, simple, atheoretical, and

47 *De virtutibus Martini*, III.16, II.4; Van Dam (trans.), *Saints*, 266–267, 231.

little concerned with etiology or prognosis. It excited no comment from medical writers because it had nothing distinctive about it. Even the much-vaunted medicine of the Islamic *bimaristan* may not have been so superior as was once thought, if the casebooks of Razi, a ninth-century medical writer and hospital physician, are any indication. Although physicians often attended inmates at several of the earliest hospitals, they had no professional qualifications—none was to be had—probably rendering them not much different in competence from nurses and other attendants.⁴⁸

A clear answer to the question raised at the outset of whether early hospital history belongs under the aegis of MacMullen or Brown is hardly possible. With MacMullen, it would be easy to conclude that, overall, hospitals seem to have made more difference in Christian milieus than in Jewish or Islamic ones (early Jewish hospitals are too obscure, Islamic ones too few), and that eastern Mediterranean hospitals were more significant than northwestern European ones. This article tries to show that although hospital history cannot be dissociated from founders' interests and motivations, hospitals were hardly irrelevant in the life of the poor, not least because of the limitations of their self-help mechanisms. Charitable hospitals reached out into their local populations in ways that historians often ignore because of their emphasis on medical functions. This argument must, however, be tempered by a Brownian awareness of the labyrinthine nature of the subject. A hospital housing a few people with basic needs is a surprisingly complex phenomenon—at once an invention and an evolution, patchy in its geography yet far-reaching in the history that it implicates.

48 Van Minnen, "Medical Care," 153; Miller, *Birth*. Summarized in this paragraph is Horden, "How Medicalized were Byzantine Hospitals?" in Neithard Bulst (ed.), *Sozialgeschichte mittelalterliche Hospitäler, Vorträge und Forschungen* (Stuttgart, forthcoming), LIII. See also *idem*, "The Millennium Bug: Health and Medicine around the Year 1000," *Social History of Medicine*, XIII (2000), 214–215; Peter E. Pormann, "Theory and Practice in the Early Hospitals in Baghdad: Al-Kaškārī on Rabies and Melancholy," *Zeitschrift für Geschichte der Arabisch-Islamischen Wissenschaften*, XV (2002/2003), 198–199.