Giorgio Milanesi
Caring Architecture in the Middle Ages: Models and Anti-models for the Contemporary?

Abstract
The theme of care structures has always accompanied the development of Western society. The advent of Christianity attempted to systematize the dynamics of reception by proposing solutions on an urban and extra-urban scale which inevitably changed over the centuries as the settlements changed and the cities themselves changed. A reflection on contemporary healthcare architecture must, however, take into account the variations that occurred between the Middle Ages and the modern age to critically question the different solutions that have gradually been proposed in individual contexts.

When we consider the genesis of organized welfare structures we have necessarily to start with the hospital founded by Basil, future holy bishop of the city of Caesarea, now Kayseri in Cappadocia, Turkey. Built extra moenia with an adjoining church and monastery, it came into being around 370 in close relation to the Basilian monastic conception, which flowed into a rule that predated the Benedictine one by about two centuries; this rule was aimed at the spiritual and physical care of the person as one of the most edifying Christian acts. The idea of creating places intended for care cannot be separated from the idea of the good Christian who must care for the soul and at the same time fot its container, according to that doctrinaire reference to *Christus medicus* that, from a hagiographic point of view, will find fulfillment in the "medical saints" Cosmas and Damian. In pre-Christian antiquity there were, of course, places for the care of the needy, but it was mostly run by families with rare cases of partial communal management of slaves or wounded soldiers returning from endless military campaigns.

What jumps out at us regarding the first organized experiences that we label for convenience " charitable " in the centuries of late antiquity and throughout the early Middle Ages is the, we would say today, polyvalent character of the services offered. The earliest *xenodochia*, whose etymology, not surprisingly, refers simply to a kind of "refuge for strangers," in the evidently all-Christian sense of unselfish welcoming to all, offered help to various types of "needy" people: certainly the sick, but also the poor, those with ambulation problems, the elderly, orphans, beggars and, of course, with great fortune in later centuries, pilgrims. It is necessary, however, to wait until the end of the 8th century, with Alcuin bishop of York, to be certain of the substantial coincidence between *xenodochia*, hospices and

Fig. 1
Plan of the Abbey of St. Gallen, 9th century, Cod. Sang. 1092.
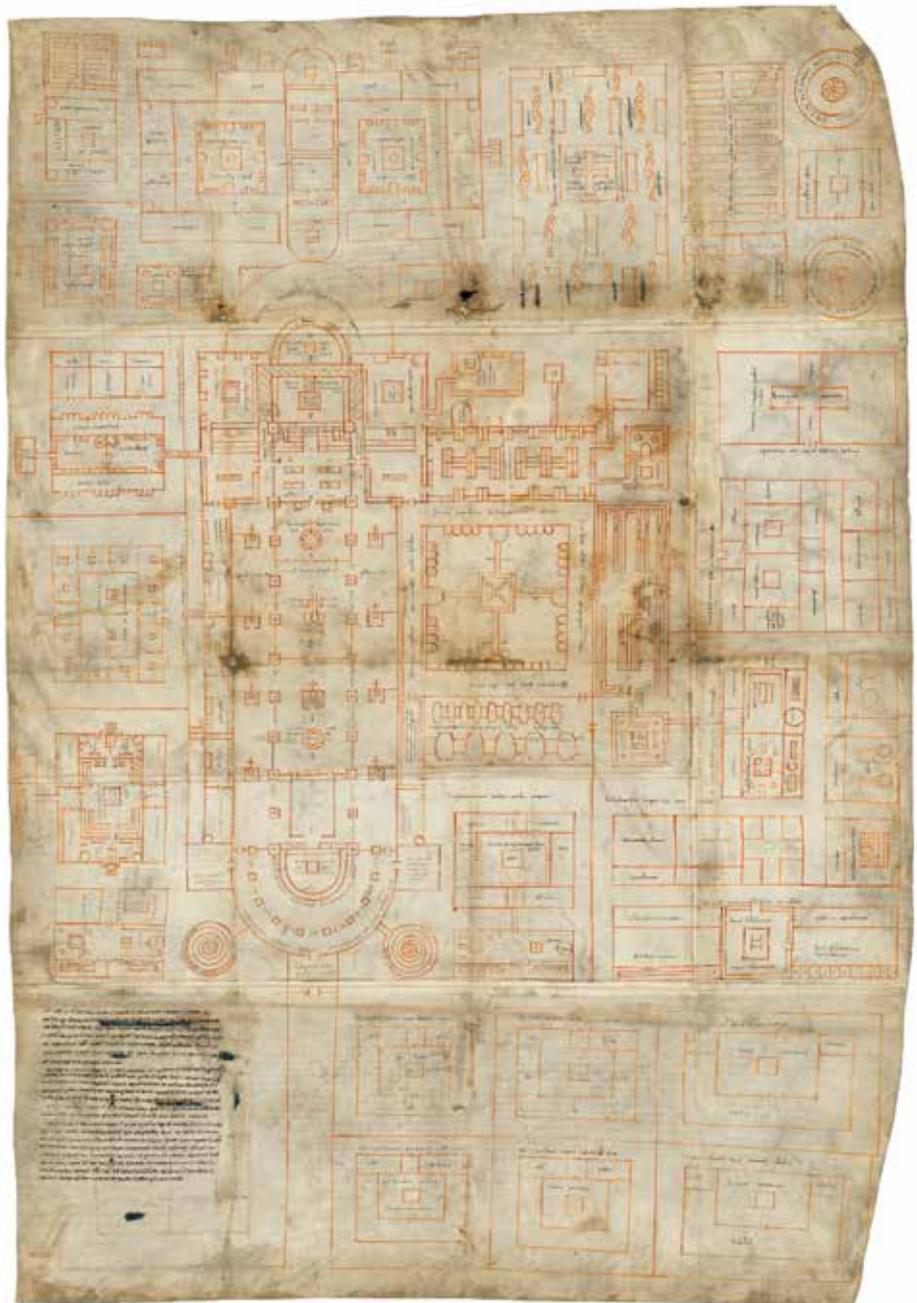
hospitals, suggesting a linguistic division that was not easily found in the factual context. For these centuries, and basically until the High Middle Ages, we are not able to identify architectural specificities, except by resorting to purely monastic models, with the caution, however, that the planimetric typology of the monastery consisting of a church, cloister on one side and adjoining spaces around it is a model that is substantially established in the late Carolingian period, leaving a textual and archaeological gap that is difficult to recompose for the previous half millennium. Since Pre-Carolingian monasteries were admittedly fenced-off places, tending to be isolated, although mostly visible, away from or on the periphery of towns, in which monks lived in separate spaces with the exception of the church, we must imagine that the structures that housed monks were the same as those that housed the needy. This at least seems to be suggested by the celebrated plan of St. Gallen (Fig. 1), from the first quarter of the ninth century, a plan that is more ideal than real, but nonetheless useful for reasoning about the spaces of a Carolingian monastic complex and thus of all Europe ruled by Charlemagne. The infirmary, houses for traveling monks, important guests, pilgrims and the poor are shown, as well as the bathhou-

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Fig. 2
Fossanova, infermeria dei conversi (Photo by G. Villa, from E. Gullotta, *La "costruzione" di un modello: l'impiego degli archi-diaframma nell'edilizia civile ducentesca del Basso Lazio*, Studi e ricerche di storia dell'architettura. Rivista dell'Associazione Italiana Storici dell'Architettura, II, n. 3; DOI: 10.17401/STUDIERICERCHE-3/2018-GALLOTTA).

Fig. 3
Plan of the Fossanova Abbey, early 13th century (from C. Enlart, *Origines françaises de l'architecture gothique en Italie*, Paris 1894, p. 26); in evidence, the lay brothers' infirmary, detached from the spaces reserved for the monks, adjacent to the water.
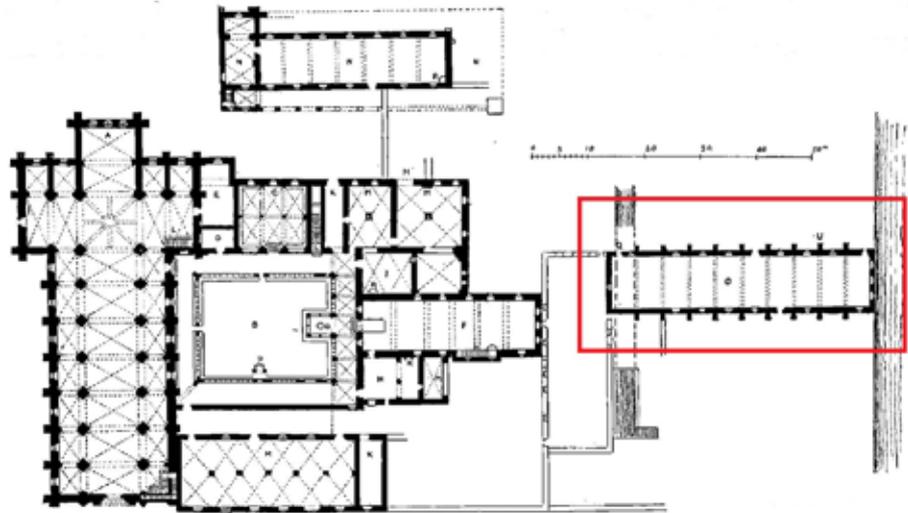
se, kitchen, medicinal plants, doctors' quarters even the salassium room. In the literature, the two fundamental step changes are that identified between the the end of twelfth and the thirteenth century and that of the fifteenth century, actually as a long wave of the Black Death of the mid-fourteenth century. In the first case there is an exponential increase in foundations for assistance in Europe, an increase dictated by new general conditions (the so-called Revival of the 12th century), conjunctural ones (the increase in the number of pilgrims with the Crusades), and political ones, in reference to a greater number of actors at play. No longer are there only the Benedictines, their Cluniac "spin-off", and the bishops to carry the burden, but now we can also encounter new orders such as the Cistercians, the Premonstratensians, monastic-chivalric orders such as, precisely, the Hospitallers of St. John, and finally, in the decades at the turn of the 1200s, the Humiliati and then the beghine movement, and immediately afterwards the mendicant conventual orders, Franciscans and Dominicans. Among the actors in play, in the 12th century the laity also entered powerfully, both in the communal and proto-state forms of the great European powers, but also in new forms of Christian evergetism by which the setting up of a welfare structure no longer had anything to do with the Christian spirit and became mostly only a public manifestation of power, resulting in the rise of a new secular sanctity between the late 12th and 13th centuries, a phenomenon on which André Vauchez has written seminal pages. However, the 12th century is also unanimously considered the temporal range of the rediscovery of the centrality of the city. The effects are immediate: cities become wealthier, the greater the attraction of population, hence greater problems of care management, consequence: exponential increase in the number of hospital facilities. It is no coincidence that the Salerno Medical School reached the height of prestige in the 12th century, and by the first decades of the 13th century physicians wanted by the municipality appeared for "collective" care.

However, this does not mean that hospital facilities became "medical clinics." The earliest Benedictine survivals in relation to infirmaries or spaces for care in general date from the 12th/13th centuries, but it is evident, as in the case of Canterbury, Ourscamps or in Fossanova itself (Figs. 2-3), the dependence on church and monastic planivolumetric models in general. It is precisely in these phases, however, with the renewed and intense involvement of the laity, that the typology of the hall hospital begins to gain strength, which Fabio Gabbrielli (2020) specifies has nothing to do with the various *Hallenkirchen* models and rather we need to think of quadrangular spaces, whether or not divided into two or three naves, covered va-
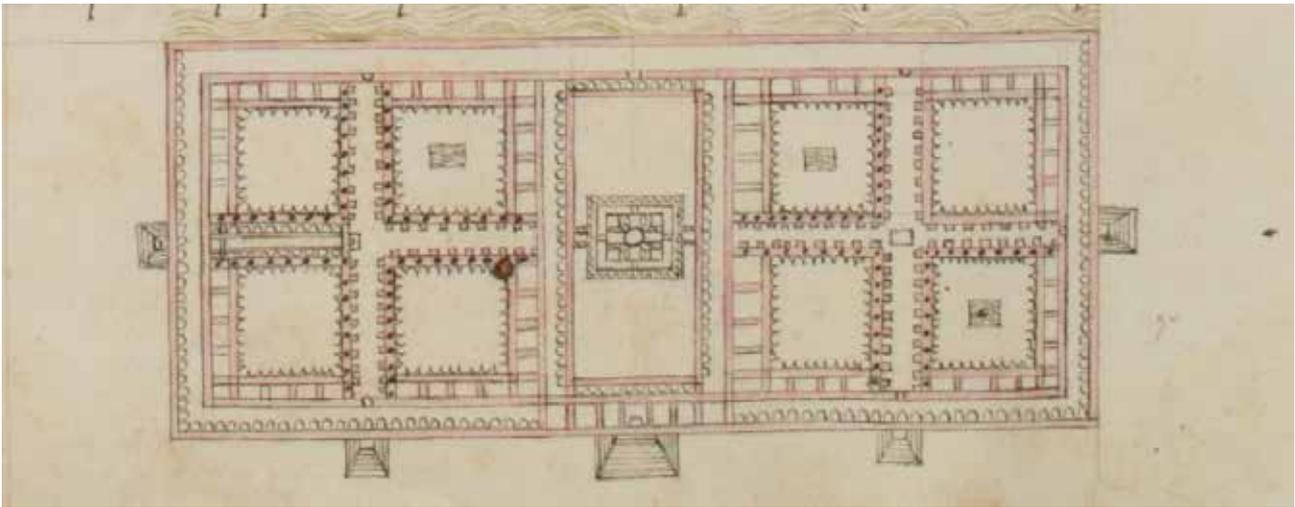
Fig. 4
Filarete, Plan of the Ca' Granda (Ospedale Maggiore) of Milan, from Trattato di Architettura, 1464 ca. (https://archive.org/details/mss.-ii.-i.-140-images/page/n183/mode/2up).
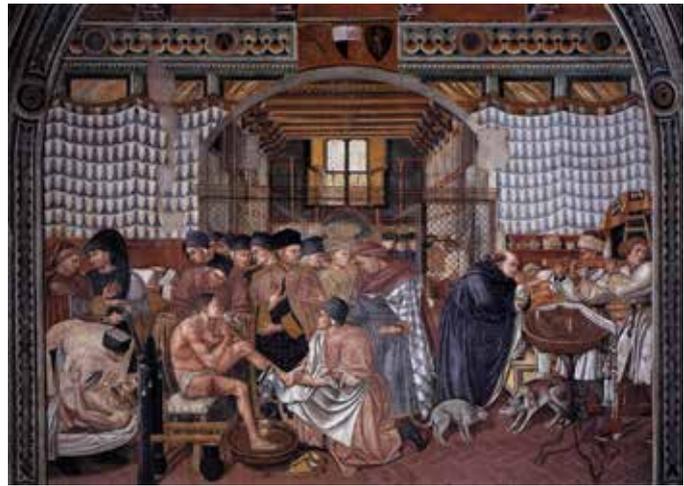
Fig. 5
Milano, Ca' Granda (Ospedale Maggiore), today, home to the University of Milan.

riously with exposed trusses or vaults, and very longitudinally developed with the only addition of a chapel inserted in the perimeter itself or in the immediate vicinity.

It's now accepted fact that there is a connection between the great health crisis caused by the plague epidemic of about the middle of the fourteenth century and the great second change of pace, that of the late fourteenth/early fifteenth century, with the emergence of new mammoth structures (hence the various "Ospedale Grande" or "Maggiore") that saw the fixed presence of physicians (or apothecaries), gradually abandoning the multipurpose as well as polycentric character of care facilities that had characterized the reception system in the previous thousand years. This is counterbalanced, as is well known, by a different architectural model, the so-called cross-shaped layout (Fig. 4), a layout on which many scholars have focused in recent decades in order to understand primarily its origin-from Pavia, from Milan (Fig. 5), from Brescia, from Florence...-and, above all, its design intention. In general, the plague had taught that the dispersion of care spaces had not optimized the response to the pandemic. Having myriad locations scattered throughout the territory had proven ineffective, no matter how strategically located or along obligatory thoroughfares. The response was therefore a concentration of welfare facilities, now less multifunctional, certainly more specialized, and tending to be linked to a secular power no longer the almost exclusive preserve of the Church or religious orders (Figs. 6-7). However, it is clear today that the "Great Hospitals" model had not been applied uncritically; on the contrary, where it was understood that the specific conditions of a city or territory led to the strengthening of the old model of widespread welfare architecture there was a tendency to

Fig. 6
Florence, Biblioteca Medicea Laurenziana, Ms. Gaddiano 247, early 14th century (http://www.culturaitalia.it/viewItem.jsp?language=it&case=&id=oai%3A-scalarchives.com%3A0009678).

Fig. 7
Siena, Ospedale di Santa Maria della Scala, Domenico di Bartolo, Cura dei malati, 1440-1441 (web source)

optimize the coexistence of new and old systems.

Tapping into architectural history as a catalog of solutions on which to set new design systems, as is well known and, I might add, obvious, is a very delicate operation. It becomes an almost foolish operation to assume for other contexts the "geometry" of an architectural complex designed for a specific space and time, with as many specific needs and purposes: the risk of the "Las Vegas effect" is just around the corner. These obvious considerations become perhaps more pregnant if we think of architectures dedicated to care in a broader sense; I find it more intriguing, if anything, to question the reasons for the choices that from time to time determined individual projects, to investigate the religious and "political" actors at play, to study spatial innovations under equal environmental conditions, to collate different projects. A PRIN entitled *At the Origins of Welfare (13th-16th Centuries). Medieval and modern roots of the European culture of assistance and forms of social protection and solidarity credit.* was dedicated in 2015 as general reflection, including architectural reflection, on these issues. Well, although studies on the medieval and early-modern welfare system were not lacking for the Middle Ages as much from a historical point of view as from an architectural history point of view, a general (and global) reconsideration of the issue has contributed in the very last few years to the publication in Italy and elsewhere of miscellaneous volumes that, if on the one hand, offer broad reconstructive scenarios of the origin of welfare systems (Bianchi 2020, also for its impressive bibliographical apparatus, has become a reference text to be complemented by the very recent Barceló Prats 2023), on the other hand, through specific case-studies (e.g., Siena, on which Gabbrielli 2023 most recently reports), a perhaps too ideological conception of the problem of medieval and modern care practices has been partly reshaped in favor of a more specific analysis of contexts. And one of the outcomes that such specific research has strongly suggested is that at some point at the end of the Middle Ages, there emerged enterprises, we would say today, mutatis mutandis, "private state-sharing" designed for public welfare (Figs. 8-9). These were structures certainly connected to ideals of propaganda and self-promotion of the ruling classes, but at the same time, without going so far as to arrive at an overly idealized image of welfare between the medieval and modern ages, connected to the revolutionary idea for those times that the greater the number of people in a given territory who could have decent standards of care, the greater the wealth and general welfare.

This aspect certainly deserves all the attention because it projects the care issue, already in the Middle Ages, in a dimension that goes beyond the architectural, anthropological, social or banally health issue. The discussion

Une salle de l'Hôtel-Dieu de Paris.
(Gravure sur bois du XVIe siècle. Biblioth. de Bruxelles).

Fig. 8
Paris, Musée de l'AP-HP, Jehan Henry, Livre de vie active de l'Hôtel-Dieu de Paris, ms. n. 59, fol. 77, Cura dei malati, 1482 (https://www.calameo.com/read/0040218272001b4dbfc02).

Fig. 9
Parigi, Hôtel-Dieu, wood engraving, circa 1500 (https://iiif.wellcomecollection.org/image/V0014307/full/full/0/default.jpg).

of possible medieval and modern models or antimodels, in order to have useful repercussions on the most recent design solutions tending toward integrated systems of care starting from an urban scale, should focus on the problem not so much and not only of efficiency, which is certainly an inescapable aspect, but also on the question of the real impact on the daily well-being of a community. It seems to me that this is the real bottom line: no architectural model in almost two thousand years has solved the issue, but multiple models adapted to individual territorial contexts has led to increasingly satisfactory outcomes. While it is clear that Community Health Places and Centers recall, at least on paper, the earliest late medieval and early medieval multifunctional hospitals, they depart from them in their polycentric character, based on spatial distribution in a given territory, which could invariably have been lowland, sea, road, coastal or river town or valley territory. In contrast, the "spatial thickening" of the late medieval and modern *Ospedali Grandi*, the model of which is sometimes still applied, concentrated care on the urban level, but the extreme medical specialization caused all other equally necessary services to the person to be lost sight of, diluting them into rivulets with little or poor communication between them.

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