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## Sanctuaries, Gateways: The Sonic Spaces of Curative and Palliative Music in Medieval Cloister and Infirmary

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The medieval monastery or convent was characterized by specific patterns of sound. Within it were spaces dedicated to particular functions, each of which generated patterns of sound that changed over time. The library, for example, started as a place of considerable noise, as readers pronounced aloud the texts before them; it later grew quieter, as silent reading became the norm. Spaces concerned with the raising of animals, the transport of objects up steep slopes (at Mont-St-Michel this involved the use of pulleys), or the production of wine or cheese each had their characteristic range of sounds. These could be either amplified or deadened by the space's interior surfaces, and could be altered by advances in technology and changes in architecture or interior furnishing. The infirmary (also *infirmaria* or *infirmatorium*, later *firmary*; in English, *fermary*, *fermory*, or *farmary*), in

which the sick and dying were cared for, was no exception.

The monastic infirmary is of special interest because of the music associated with it and because of the apparent changes in its sonic environment that occurred during the later Middle Ages. This preliminary study will discuss one musical ritual from the early Middle Ages, many of whose details have been reconstructed. It will then examine the sonic environment of the monastic infirmary in the following centuries, taking into account both the features of the built environment and the range of audible events occurring within this space.

It is not difficult for us to imagine that music would have been used within the infirmary and adjacent chapel to reduce discomfort from disease and injury and to ease the passage from life to death. But establishing the characteristics of this music, and situating it within its physical setting, requires attention to both the total sensory and affective experience, as well as to the acoustic properties of the built environments in which this music would have been heard.

The physical and cultural context of these sonic experiences cannot be separated from the theological frames of reference that informed them. Moreover, all music heard in a cloister, unlike the studio-produced “piped in” sounds of a physician’s waiting room, was created by individuals known to one another and usually known to the listeners, adding an interpersonal dimension seldom addressed explicitly in medieval documents but of great importance to all involved.

Music-thanatology is a modern day palliative medical modality employing prescriptive music to tend to the complex physical and spiritual needs of the dying. It claims as its ancestor “infirmary music,” an intimate expression of monastic medicine in eleventh-century Cluny, which may have anticipated, as some healthcare providers suggest, the holism of both the hospice and palliative medical movements by almost eight centuries (Schroeder-Sheker, 1994).

Precursors of this infirmary music may be found in the pre-Carolingian *ordo penitentiae* for the dying and in the Carolingian rite of anointing the sick, which calls for the singing of the office for the sick members of a monastery for seven days. Hymn singing may also have played a role in the care of the sick and dying in the earliest history of the Church. These ceremonies were “ideally suited to concentrating the mind of the dying man and lifting him out of the pain of his agony” (Paxton, 1985, p. 81).

Glimpses of early medieval infirmary music are found in the “Cluniac Customaries,” which detail the rituals of dying. In the death ritual, the seven penitential psalms were sung “without ceasing,” along with special antiphons. The Credo was also sung, an innovation that appears to have originated in Cluny. Yet even at this late stage, the rite of passage still invoked rituals of curing, as seen in this antiphonal response:

God, who gave fifteen years to the life of your servant Hezechiah, in the same manner, through your power, raise this your servant from his sickbed and to health.

At the actual moment when the sufferer died, boards called *tabulae* were struck *crebris ictibus* (with swift blows), which summoned the other monks.

In Cistercian monasteries, the ritual varied somewhat: monks returned to the litany if the patient still lived, and then, at the striking of the *tabulae* during the Credo, they re-entered the infirmary to minister to the sufferer. In this ritual, the dying monk was first separated from and then reunited with his earthly community through his confession and reconciliation, events that were multi-sensory but fundamentally auditory.

Since hearing, often outlasting sight and speech, is the sense that usually functions until the end of life, the auditory connection was especially important during this two-way trip away from and back to the community. After the patient's decease, *conversi* would ring bells and a litany would be recited.

The Cluniac model proved profoundly influential, shaping comparable rituals of other religious orders for centuries to come.

Modern concepts of healing and curing should only be applied to the medieval monastic infirmaria with great circumspection. Not only could few patients be "cured" by the standards of modern medicine, but also the objectives of the modali-

ties offered were fundamentally different from those sought today in most medical environments. Our examination of these sonic environments recognizes the primary importance given to care of the soul (*cura animae*) and also to the sufferer's relation to both the earthly community and the community of heaven whither s/he might be bound. St. Benedict's message regarding this care was vivid:

[The Abbot] must bear in mind that it is the care of sick souls that he has undertaken, not a despotic rule over healthy ones. (cited in Flint, 2000, p. 158)

Any therapy, including music, had to give at least as much attention to the sick soul as to the body in which it was encased, and in fact the arbitrary separation of the two would have seemed unnatural to contemporaries.

The aesthetic economy of the religious community required these sonic experiences both to be generalizable to others and to address the journey to the next life (as understood via Christian theology) that the patient might soon be making. Thus, the presence of God is assumed in each of these events; He is both a listener and a participant in the creation of music, which Hildegard of Bingen, among others, regarded as a manifestation of spiritual wholeness.

The Divine was present in the infirmarium in another way, as Benedict noted:

The care of the sick is to be given priority over everything else, so that they are indeed served as Christ would be served... .<sup>1</sup>

On occasion, the dying monk or nun might himself or herself contribute to the music, a reminder of the essentially communal nature of the therapy. In less dire circumstances, the infirm might still have ongoing access to the Divine Office, either through speech or song. A testament from 1161 indicated that a church in the monastery of Santa Sophia in Benevento was to be built specifically to provide this access.

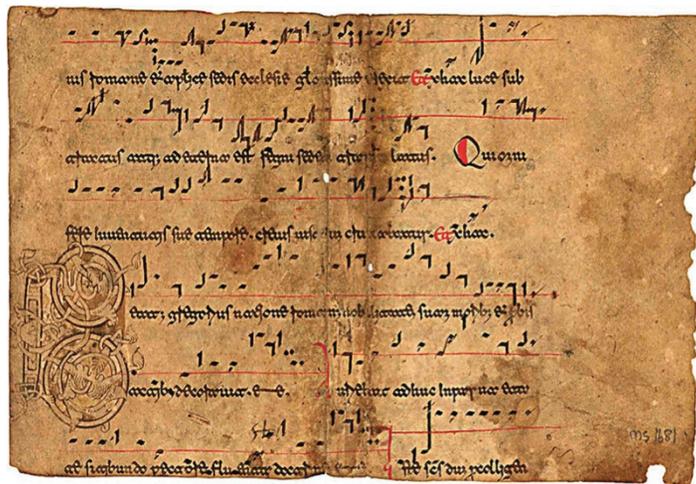


Figure 1: A music manuscript in the Beneventan style, dating from the second half of the 12th century. The red lines represent the pitch F, and helped singers to gauge the relative pitches indicated by neumes above or below the line. The text is the Vigil sung for St. Benedict: <http://www.schoyencollection.com/music2.html#7.12> [November 26 2013].

At other times, the sick sang together in the infirmary. In one of his letters to Héloïse d'Argenteuil, theologian Peter Abelard recommended that the sick celebrate the Hours of the Divine Office, although he did not specify whether this must be a solitary or communal act.

A passage in the Customaries of the Cistercian community of Cîteaux clearly states that the inmates of the infirmary are to sing when the Vigils are sung in the choir, indicating that sound could travel from the choir to the infirmary. Musical companionship in these settings had another function as well: it provided protection from the Devil, who constantly lurked, waiting for moments of human weakness and despair, and who produced his own set of characteristically unmusical sounds, among them cackling, farting, bellowing, and mocking speech.

Singing together, in a community where speech was closely regulated, was also an opportunity to express emotions audibly and to enter into a communal auditory experience. While the daily Divine Office conducted in the choir offered multiple opportunities to do both of these things, the special circumstances of the infirmary gave such outpourings added affective value.

In addition, we note that not everyone in a monastic infirmary was necessarily ill: during the later Middle Ages in some establishments, senior monks who had grown tired of the common life might retire to the infirmary, which often offered better food and general comfort. Thus, those able to hear music performed in or near the infirmary

may have included some not facing the anxieties and discomforts of the seriously ill. Since these men would typically be older and more influential members of the community, their mere presence suggests a change in the power relations within the infirmary, with possible implications for what kind of music was performed there, and in what way.

Some monasteries maintained a separate *infirmarium fratrum* for conversi, which suggests variations in status among those within a general infirmary. The occasional expulsion of *famuli* accused of purloining food for their own families points to further tensions within some infirmaria and to another range of sound potentially audible to their inmates.

Corrodians, well-off seculars who had purchased a life annuity from Westminster Abbey, probably lived in its infirmary. Their presence would have introduced yet other elements into the sonic environment toward the end of the Middle Ages. In addition, the infirmary's chapel might have been used by bishops, other clergy, or nobility for their own purposes, as in the case of a wedding held in 1405–1406 in the infirmary chapel of Westminster Abbey.

Music in the monastery setting was created for very different categories of auditors in the context of many other communal activities, from eating, to working, to praying, to medically driven practices such as bloodletting (and recovering from bloodletting). Moreover, the connection between healing, comfort, and music in the motherhouse of Cluny

(and perhaps in other settings) was reinforced by literal and allegorical representations of health and music, such as surviving figurative capitals depicting the four humors. Symbolism and allegory, in a world where all things might be read allegorically, extended to the infirmary itself: the fourteenth century devotional compendium *La Sainte Abbaye* equates compassion with the infirmary's structure. Thus, the music performed would have had the potential for symbolic as well as concrete meaning, acknowledging the unseen presence of a divine Auditor and the function of the infirmary as a place where His mercy and compassion were made manifest.

We should not forget that the singing of Mass was used from the early Middle Ages onward as a curative act to protect livestock and humans. For example, *Lacnunga*, a tenth- or eleventh-century Anglo-Saxon book of remedies, recommends singing masses over swine as part of a process to shield them from disease. At this point, the line between holy song and magical incantation becomes almost invisible, a blurring that may have remained in the minds of conversi and others within the monastery or convent, colouring the experience of the infirmary.

The experience of this music must also be placed in the context of *silentium*, a concept that extends beyond the mere absence of sound. Among the range of meanings of medieval *silentium* is "tranquility," a state with positive attributes. *Silentium* had another positive association: that of the conscious reverence paid during the

reading of auguries, upon which St. Augustine drew in his famous passage in which he encounters St. Ambrose reading silently. *Silentium* was thus far more than a pause in the sonic event; it was an integral part of it, and one that lent value to the music.

And just as the sounds of factory or forge define their spaces, the wider *silentium* of the monastery or convent—in comparison with the noises of town or countryside—delineated its precincts and the special power residing within them. *Silentium*, in communities such as the Cluniac where speech was restricted, not only provided contrast to the ritual sonic events of each day, but also was itself a profound sonic event.

*Silentium* was one characteristic, perhaps even a dominant one, of the infirmary, one that framed many events, musical and otherwise. This *silentium*, moreover, was experienced in an environment where the dynamic range of sounds encountered was much narrower than in a hospital today: even its louder sounds would seem subdued to us. To distinguish between sound and *silentium*, a nun or monk would have employed keener auditory skills than are at the disposal of many modern city dwellers.

The absence of sound figures in other ways in the performance of late medieval music in these spaces. Within a musical performance, brief silences—expressed in notation as “rests” by Franco of Cologne (?-1200) but perhaps of earlier origin—are meaningful sonic events, essential to the comprehension of texts and greatly enhancing the

appreciation of complex polyphonic compositions. Franco's notation of rests is less of an invention than an acknowledgement of an absence of quantifiable sound, an event that coincidentally is contemporaneous with the introduction of zero into mathematical notation in Europe. The silentium of the monastery was a quality known to its residents long before musical notation acknowledged its existence, yet this notation further clarified its existence and situated it within musical events.

Medieval infirmaries in the Latin west were often built as vaulted halls, with a chapel located either within the infirmary itself or communicating with the infirmary through a door that allowed patients to hear religious services. No rood screen separated the sick from the music. The power to heal was thus linked to the acoustics of the liturgy.



Figure 2: Scenes from a 13th century monastic infirmary. Barefoot indigents apply for admission in the top left. In the right hand panels, the souls of repentant and non-repentant patients rise to heaven or are carried off by winged demons, respectively:  
<http://www.dps.missouri.edu/resources/orient/images2/history/mnsty02.jpg> [November 26, 2013].

The Infirmary Chapel at Cluny, completed at the end of the eleventh century, had triapsidal chevets, transepts with towers, and wide, wooden-trussed naves, creating an environment whose visual and acoustic aspects addressed the spiritual mission of the infirmary. In England, spacious and imposing infirmary chapels were attached to Cluniac houses, and organ music may have complemented the other sounds heard in them.

The communal aspects of these facilities and their great importance to the monastery are suggested by the scale of the infirmary of the Cluny motherhouse, which could house one fourth of this very large community. Despite the close quarters described in the Customaries, some infirmaria could be of considerable size, with commensurate acoustics. Anne Walters proposes that an oratorium at the Abbey Church of Saint Denis may have been a converted infirmary (Walters, 1985). On the other hand, the infirmary built at Saint Albans in the thirteenth century seems to have been a more modest structure of wood, which, if it lined the building's interior, would have produced a more sound-absorbent space.

Jürgen Meyer (2009) has argued that the creation of visual emphases in concert halls improves the sonic experience. In a medieval chapel, focusing attention on the altar, or on an architectural detail such as a stained glass window, accomplished two related objectives. By reinforcing the content of the liturgy with specific imagery as well as the abstract patterns of light created by glass windows, the designers of these spaces sharpened

the listener's auditory experience, providing images for words (which were being intoned in a language perhaps not too familiar to the listener). At the same time, they were affirming St. Bernard's observation that "hearing leads to sight" (p. 223).

Hearing and sight could be linked further by focusing attention on the preacher. The Cluniac infirmary chapel in Castle Acre, Norfolk, shows the remains of a pulpit dating from perhaps the twelfth century. Smaller, more portable objects such as wooden crucifixes filled a similar function within the infirmary.

The figure of the celebrating priest, as both a visual and audible reference point, is also crucial to the sonic experience. The emphasis placed on particular images or symbols visible in chapel or infirmary provided the raw material for visionary experiences, which might contain both visual and auditory elements, and which contemporary accounts do not, of course, distinguish from experiences more rooted in the empirical world. Thus, the total sonic experience of the monastery or convent, including in the infirmary, was never bounded by the acoustical limitations of any particular space.

The absence of silentium was a net loss for a religious community and for any sacred space, and could earn severe punishment for those who caused a disruption. Late medieval sacred spaces were plagued with such disruptions. In contrast to the order and calm implied in the Cluniac Customaries, an acute awareness of the lack of silentium runs through the reports of fourteenth-

and fifteenth-century visitors to the parishes in the archdiocese of York, in which the noise of clog-wearing singers in the Cathedral choir and other noises were noted with disapproval. The disciplined care of the infirmarium seems to have steadily declined in the later Middle Ages. Lack of silentium in the infirmaria was of particular concern in this later period: William Melton, a fourteenth-century Archbishop of York, wrote of “inappropriate conversation ... in the infirmary.”<sup>2</sup>

A prohibition from the first half of the fourteenth century, directed at the infirmarium of Hexham Abbey, suggests a few more potential sources of sound, including “raucous drinking and game playing.” At times, when seculars were in a convent’s infirmaria, bringing necessities to the sick and causing disquiet among the sisters, injunctions against “superfluous et vain conversations” were issued.

Inappropriate sound (especially speech) was closely linked with other impure or distracting actions. For example, in 1453, a barber was enjoined to stay away from an infirmaria of the convent of Notre-Dame-aux-Nonains (*infirmaria* here refers to a sister working as a nurse), under pain of excommunication (McDougall, 2008).

Paradoxically, while the illumination of an object or region within the listener’s visual field can enhance the auditory experience, the total absence of light can do much the same thing. In the cloister, the nocturnal *officium* might have been recited in complete darkness, to spare eyes and candles. The generally darker interiors of many monastic struc-

tures, and the lower level of light in pre-electric Northern Europe, both accustomed listeners to attend to music in the dark and encouraged the connection between light and celestial splendour, including music, as found in the writings of Hildegard and Abbot Suger.

Taken together, the generally low (by modern standards) level of sensory simulation and the guidance embedded in monastic discipline directed the entire community, including those in the infirmary, to attend to subtle changes in the sonic field.

The range of sensory stimuli associated with the care of sick and dying members of the monastic community therefore consisted of highly integrated elements that were probably not always experienced as discrete events, and which were influenced by the plan and choice of materials of the infirmary or chapel. Straw or straw matting on the floors, wooden ceilings—especially when unpainted, or presenting concavities, prefiguring the acoustically enhanced “coffered ceilings” of the Renaissance—statuary, brass doors, tombs and fittings, and sheets of stained glass all affected the acoustics of these spaces. For example, when the glass windows of the Lady Chapel of Ely Cathedral were removed during the Second World War, the acoustics changed markedly. And as Craig Wright has shown, the use of cloth wall hangings during feast days and the shrouding of the altar to create a *tabernaculum* affected the experience of sound within the nave of a cathedral. These tendencies would be still perceptible in the smaller

space of an infirmarium chapel. Wall hangings of worsted curtains and cushions, all found in late medieval infirmarium parlours, also absorbed sound, as did the large wooden chests that the residents sometimes brought into the infirmarium.

A musical event is comprised of many elements. Among these is the *timbre* of the sonic event, one dimension of which has been defined as “flux,” referring to how a sound changes over time while it is being played. Other aspects of timbre include the presence of overtones and other qualitative factors that allow two sounds with the same pitch to be distinguished from one another. That monastic communities were conscious of timbre is suggested by their use of terms that describe changes in vocal quality, as opposed to pitch, in the performance of chant.

Each of the elements of timbre played an important role in the experience of music in the monastic infirmaria, as did the more general (if controversial) late medieval tendency for vocal performance in higher registers. These non-notated facets of musical performance have great affective potential, summoning up feelings of jubilation, hope, despair, or erotic desire, and shaping the comprehension of Latin texts that may have been only imperfectly understood by some of their listeners. The potency of timbre, especially in the upper ranges, was sufficiently impressive to the founders of the new and austere religious orders of the twelfth and thirteenth centuries to cause them to ban these sounds. Yet these higher ranges remained present in many musical settings found

within the cloisters of the fourteenth and fifteenth centuries.

While they can only be recreated with approximate accuracy, each of these non-notated elements must be kept in mind when considering the musical interaction that took place in an infirmary. The location of the musical event within the monastic complex and the propagation or impeding of sound within the space are also important: in St. Augustine's Canterbury, a servant or monk might play the harp for the infirm in the infirmary chapel, but not in the infirmary itself. On the other hand, the Office for the Dead, undertaken with the deceased stretched upon a slab in the infirmary chapel, might be spatially localized but very audible to the inmates in the adjacent cellulae.

To these elements must also be added the traces of sounds characteristic of monastic life, at once communal and solitary: the footfalls of an approaching brother or sister, the rustle of robes and clatter of dishes, and at times the sounds of animals kept within or near the infirmary complex (there are reports [Classen, 2012; Harvey, 1993 Kerr, 2009] of pet goats, squirrels and other creatures living indoors, and an infirmary garden might have had a dovecote to provide meat for the inmates). The private prayers of other members of the community and quietly hummed or sung Psalms would have been audible as well.

To these can be added two other characteristic sounds heard in the vicinity of the infirmary: that of wood being sawed, since this activity was recommended to help restore health, and of steam

and boiling water, as the infirmarium might have prescribed the “sweating cure.” Along with the patterns of litany and music, the routines of cloistered life would have prompted feelings of anticipation. One’s familiarity with the habits and quirks of those with whom one had lived for decades would have been triggered by sonic cues.

When considering the infirmaria of the fourteenth century and later, another very different type of anticipation associated with sound must be kept in mind. The Black Death of the 1340s and its subsequent recurrences had devastating consequences for cloistered communities. The onset of the disease had discernible sonic characteristics: the coughing up of blood and the horrifying sound the plague buboes themselves made as victims attempted to move. Such sounds must have struck terror and dread in all who heard them.

This spectrum of sound reminds us that a documentary history of the sonic environment of the cloister faces two interrelated challenges. Surviving manuscripts may owe their survival to chance and may reflect atypical circumstances that merited special description. Less frequent use could have also increased the chances of a record surviving. In addition, the most common sonic events in a monastery frequently escaped notice in such documents precisely because they were so common—yet the very ubiquity of such sounds made them an important part of the experience of the cloister.

The music performed in infirmaria and in adjacent chapels, like other products of monastic life, developed over several centuries and was refined

through practical application. It was also subject to occasional outside pressures and intrusions. While often accompanied by texts that had been written down and heard by those who could read, this music existed in an environment in which most communication was accomplished without the mediation of symbolic notation or writing and, in many cloisters, with a minimum of speech.

In this environment, the tactile, the immediately apprehended, the phonetically expressed (if not cognitively comprehended), and the intuitively grasped each gave meaning to experience. The music performed required no subtext of explanation or interpretation, existing as it did within the shared and remembered experience of the entire community. Yet we must acknowledge the complex and at times contradictory relationship between monks and their singing, which St. Anselm described as “that heavy yet singable thing.”<sup>3</sup> In the words of one scholar, writing of the motherhouse of Cluny, “A long and sometimes exhausting liturgy seems not to have included an air of joy and contentment” (Grégoire, 2002, p. 815). Music in the infirmary must have been, at various points, a release, an expression of faith, a task, a pursuit of the beautiful, a habit, and a door that opened up memories both uplifting and sad.

Some infirmary chapels were larger than the smallest churches of the Merovingian era, but most infirmary music was heard in intimate spaces. Cluniac specifications for the *cellula infirmorum* called for a space 27 feet long and 25 feet wide, holding eight beds, with a *claustra* only 12 feet in

length. Carolingian monasteries provided specific (one hesitates to call them private) rooms for gravely ill monks, or for an abbot when he was sick. Later, *infirmaria* in Cistercian monasteries evolved from large, hard-to-heat halls, into a set of individual cells. Intimacy is important to many genres of medieval music, and is especially germane to music performed in *infirmaria*. The role of the priest as celebrant of the Mass involved physical and emotional distance from the worshippers—yet the effect of his sonic performance was far from impersonal, even if his form was not visible to a bedridden inmate of an *infirmarium*. If the priest was ministering close at hand, as described in the Cluniac Customaries, the sense of intimacy would be unmistakable. The physical experience of the music, creating perceptible sensations within the body of the infirm, and the anticipation of this sonic event within the context of the temporal and spatial patterns of monastic life, all added to its significance for the entire community.

The *exemplum* or illustrative story was also presented orally to the infirm in *lectiones*. In the sounds of harmonious instrumental music, or in the psalms sung to the dying, the auditor heard echoes of performances already encountered many times in similar circumstances. With these cues he or she was called upon to play a role that would guide others' future behaviour, the music not only providing calm to the body and soul but also articulating the stability and continuity of life in the cloister.

Finally, in a realm that has yet to be sufficiently explored, we must consider the possible impact of specific sounds themselves on the physical health of the patient. Yogic medicine claims that aside from any “specific innate meaning,” the sounds “um, ee, oooh” can positively affect health (Sahannahoff-Kalsa & Bhajan, 1992, p. 188). Assuming that these claims can be substantiated, the occurrence of these sounds in the sung or spoken rituals conducted for the sick and dying may indicate yet another dimension to curative song in the medieval infirmary.

The sonic experience of the medieval infirmary was thus a subtle melding of planned and unplanned sound, of ritual designed to comfort and guide, of mundane routine that could reassure or sometimes frighten, and of less frequent outbursts or variations that lingered in the collective memory of the cloister. The scale and interior textures of the infirmary itself, the individual skills and creativity of the musical performers, and the visionary world of the spiritual in which the entire community participated all shaped this experience, which, despite the best efforts of modern musicians and thanatologists, cannot be fully duplicated today.

What we can do is appreciate the concentrated collective attention that was given to the suffering and dying members of these cloisters, and the great effort expended to place such individuals in communities—both heavenly and earthly—whose reality was affirmed through sound. These efforts are a reminder, in a world filled with manufac-

tered sounds intended to entertain, to homogenize, to nullify, and to “fill” silences, of the potential power of song, and of the communities we may yet build through its agency.

### Notes

1. *Regula Benedicti*, 36 (author’s translation).
2. William Melton, 14 October 1320, regarding the Abbey of Whitby, *Cartularium Abbathiae de Whiteby*, [=*Publications of the Surtees Society* 72] (Durham: Andrews & Co, 1881), 633. We also note the case of the monk who kept a goshawk and “Dormiuit eciam per mensem in infirmaria absque speciali licentia abbatis de nocte in noctem, et habuit secum mulieres.” *Visitations of Religious Houses in the Diocese of Lincoln: Vol. 2: Records of visitations held by William Alnwick, Bishop of Lincoln, A.D. MCCCCXXXVI-MCCCCXLIX; Part 1* [=*Canterbury and York Series*, 24] (London: Canterbury and York Society, 1919), 73.
3. Anselm, *Epistolae*, ii, 2. (author’s translation).

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