

Civic or Religious? The Issues of Governance in Late Medieval and Early Modern
Hospitals: The Case of Poland.

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Today's Eastern Europe has received a lot of attention from Third Sector practitioners and civil society researchers. The great societal and cultural changes accompanying the collapse of Communism and the arduous democratization of the region have added stimulus to such studies, as well as opened new and exciting vistas for the developing not-for-profits. Whereas many research associations have considered Eastern European nonprofits from both a local and a global perspective, studies have largely concentrated on modern Western-oriented methodology and ignored the traditional approaches to charity present within the indigenous society. While correct on many levels, on one hand such an approach tends to marginalize the local historical and cultural conceptions of charitable endeavors that might have survived for centuries, and which might still carry considerable weight with Eastern European communities, and on the other hand it masks surprising similarities in the scope and function of pre-modern Eastern European and modern Western Third Sector practices. The modern not-for-profit practitioner wishing to do work in the countries of Eastern Europe must keep it in mind that today's practices reflect the historical complexity of the region; what we learn about the past of Eastern European civil society teaches us about its present. The study and analysis of the history of these charitable practices is thus an indispensable tool in the arsenal of third sector pioneers in Eastern Europe and will add greatly to our understanding of social and religious forces behind our cultures of sharing and giving.

One of the leading debates gripping contemporary Third Sector research concerns the questions associated with the shape and role of nongovernmental organizations' (NGO) governance in today's voluntary environment. While the vast majority of contemporary nonprofits, such as mutual-aid and community organizations, are still

founded to fulfill specific, locality oriented needs and goals, the proponents of the 'pooled sovereignty' notions so vocal today, a socially loose but ideologically united amalgamation of political activists of various parties and groups, are quick to point to a common global nonprofit policy as a 'brave new world' where centrally controlled NGO institutions will be able to transcend purely local or even national self-interests and promote what could only be described as meta-concerns. The supporters of this approach revel in the continuing process of strengthening and development of the international nongovernmental organizations (INGOs) and are positing the emergence of what could only be termed as a global civil society that utilizes transnational social movements and organizations (TSMOs) as a mode of promotion of institutional policy changes in an international setting (Smith, Chatfield, Pagnucco, 1997). Only through deliberately implemented, top down [or bottom up, in the case of grassroots organizations] institutional designs in a transnational society, so the argument goes, will a full mobilization of resources and advocacy networks be achieved for the realization of multilateral policy. The surrender of NGO policy making governance structures to these supra-national concerns is, of course, the first and central step in transforming the still locality-oriented Third Sector environment we find today in an increasingly interdependent world.

The enemies of 'pooled sovereignty' notions, on the other hand, argue, and this is just the most basic of their arguments, that the implementation of strategies that manifest themselves in centrally controlled transnational social and political movements threatens the Westphalian conventions of the nation-state on which our international relations are based. Moreover, the multiple issues associated with the governance and systemic

adaptability of the proposed global networks raise questions as to their ability to successfully identify, meet, and overcome most pressing world-wide problems, to say nothing of the always present local conditions that might entirely escape the attention they deserve. The perceived failure of the representative global social and political organization, the United Nations, to meet the goals it set for itself, adds immediacy to the critics' concerns that such bloated constructs will not only be unable to manage interdependence and to meet the expectations of their constituencies, but will also lack a program to affect adequate internal change or self-evaluation (Haas, Kehler, Krasner, 1994).

Though the proponents and opponents of 'pooled sovereignty' do not agree on much, the Third Sector researchers and practitioners from both camps do agree that the questions enumerated above are some of the most serious challenges facing NGO governance today, as transnational nongovernmental organizations and social movements are quickly turning into activist forces bent on transforming international political and social norms (Khagram, Riker, Sikkink, 2002). What neither the proponents nor opponents of 'pooled sovereignty' realize, however, is that these same questions that motivate debate today, have been present, in one context or another, yesterday and the day before. History plays an important role in informing our concepts of governance of organizations designed to bring about social change.

Some researchers and scholars have realized this and moved in the appropriate direction. Organizational studies that include the historical dimension have shown transnational policies existed long before the advent of modern-day globalization, and have been used to coalesce disparate networks of activists to affect social change.

Human rights, antislavery, and women's suffrage campaigns operated across sovereignty lines and state frontiers to achieve their goals of human fulfillment (Keck, Sikkink, 1998).

It is, in fact, possible to look even further back and posit the issues of NGO governance in the context of certain pre-modern historical developments. The immense social dynamics and pressures unleashed by the campaign for Globalization led by some segments of the NGO and UN community today have their parallel in the early-modern movements associated with the Reformation and the Counter-Reformation of the Roman Catholic Church. By using the example of the sixteenth and seventeenth century developments in the administrative practices of the representative Polish and European NGO of the period, namely that of the hospital, it becomes possible to account for how these institutions, thoroughly subsumed within the then-prevalent notions of Christian charity, found themselves as front-line instruments in the religious and social struggle that redefined the entire notion of early-modern NGO governance in Europe. As these events existed within a Pan-European social and religious framework, rather than a national state one, questions of sovereignty infringement associated with globalization of today did not arise, so 'pooled governance', rather than 'pooled sovereignty' thus defined the top down administration of Polish hospitals in the post-Council of Trent scenario.

Medieval and Early Modern Polish Hospitals

Like similar institutions throughout the rest of Europe, the Polish hospital developed according to clearly delineated concepts stemming from Christian charitable beliefs and practices, which, of course, differ from contemporary standards. Healing the

sick, for instance, was considered to be just one of many functions of hospitals at that time. Even as late as 1579 the archdeacon of Wroclaw (Breslau) defined a hospital as “every place, having as its goal charitable care, which supports all those who are poor, pilgrims, ill, incapable of working, not having food or clothes, mentally ill, poor orphaned children, abandoned infants, lepers, those with terminal and communicable diseases, and all others worthy of mercy.”¹ Most hospitals acted as shelters and old age homes in addition to houses for healing the sick. There were even hospitals that doubled as schools and as places for expectant mothers to give birth to unwanted children which would then be left in the care of the establishment. The extent of social services performed by the hospital institutions in Poland was thus considerable (Kumor, 1969; Podgórska-Klawe, 1981).

Although meeting the social needs of the masses became the driving force behind the proliferation of hospitals throughout Europe in general and Poland in particular, these institutions also promoted the identification of social care with the religious establishment. Very much separated from today’s commonly held notions, alms giving, shelter and all other forms of charity were never really seen as instruments combating poverty or social inequality. The social context of help always appeared secondary to spiritual consideration. The Catholic Church simply never viewed poverty as a social ill. The existence of poverty was seen as a perfectly natural order of things, established by the will of God, as a means to help some (those who gave alms) on their way to heaven. Seen as instruments of God’s divine plan, the poor were thus viewed as a necessary

¹ Quoted in Kumor, 221; “Loca omnia pietati erga proximum consecrata, in quibus aluntur peregrini pauperes, invalidi et ad labores, quibus victus et amictus comparetur, inepti, senes, parentibus orbat, atque inopes liberi, infantes expositi, leprosi, contagiosis ac perpetuis morbis obnoxii atque aliae miserabiles personae.”

component of society, and the condition of poverty was not viewed as something that ought to be purged by concerted action. Charitable institutions were therefore not designed to eliminate poverty, but rather to aid the poor just enough to help them survive and so preserve them in the state of poverty (Góralski, 1963).

The Victory of Secular Administration, 14th-16th centuries.

The ecclesiastical establishment, of course, maintained wide-ranging rights over Polish hospital institutions from the moment of their origin in the twelfth century. No newly founded hospital, for instance, had any legal standing without the approval of its foundation documents by the ecclesiastical organs. The spiritual authority thus possessed ready-made access and an implied right of veto over every provision delineating the structure, methods, and competencies of the proposed institutions. Theoretically, at least, hospital governance thus fell squarely within the domain of the Roman Catholic Church. That private founders and, beginning in the fourteenth century, municipal councils, found a way to push through their own conceptions relating to hospital governance without having to worry too much about ecclesiastical positions was due more to a rather general lack of interest in the matter by the church organs prior to the Council of Trent and also to a wish on the part of the church to maintain its close knit alliance with the landowning classes, than to some sort of a weakness on the part of the religious authority.

The rise of new hospitals, outside of the scope of church governance, was also related to the growth of importance of the cities. By the end of the twelfth century some Polish cities became independent cultural centers. Drawing power from the developing trade routes they guarded or from natural resources in their area, municipalities struggled

for legal emancipation from the established ecclesiastical organs (Wachholz, 1921; Góralski, 1982; Podgórska-Klawe, 1981). Town councils eventually found it possible to amass power and responsibility over most urban concerns, including those dealing with charity, under which belonged the erection and maintenance of hospitals, which were perceived by the town councilors as public, and not religious institutions.

The German town-dwelling immigrants, who became the backbone of early Polish urbanization, brought to their new country their own institutions and traditions, including those associated with dispensation of charities and especially with hospital administration, where special commissions within town councils were designed specifically to run and maintain urban hospitals. These administrative developments were transcribed wholesale onto the Polish model. Polish princes and magnates, understanding the importance of a stronger economy associated with the rise of cities and German immigrant influx, were more than happy to let the newcomers design and run their own institutions as they saw fit (Wachholz, 1921; Góralski, 1982).

While the flow of municipal money into hospitals assured the presence of secular officials on their premises, the cities also had another important reason for attempting to enlarge their financial association with these institutions. Not all hospitals lacked for cash. In fact, quite a few were constantly receiving more gifts and donations than they could use. This excess usually passed on to the church organs that ran these hospitals and, as far as the municipal authorities were concerned, was wasted on inappropriate matters. The attempt by secular city groups to control the financial situation within hospitals would thus, in certain cases, assure a considerable source of income that could then be utilized for the needs of the urban community or even lent out for interest.

Financial relations with hospital institutions, therefore, represented quite a prize for money-strapped city councils (Piekarczyk, 1952; Podgórska-Klawe, 1981).

It should be stressed that the church itself condoned lay interference in hospital administration, as it also did in financial matters of particular churches. The *Quia contigit* decree of Pope Clement V, made at the Council of Vienne in 1311, exempted hospitals from being given as benefices to priests and virtually required specialized secular administrators whose competence lay in careful day-to-day management of a hospital's material property. Such a self-exclusive promulgation, appearing hard on the trail of similar considerations taken at the Council of Arles in 1240 and the Council of Ravenna, also in 1311, could be explained by the church's ardent wish to limit what it perceived as gross irregularities and corruption or simply straight incompetence of its own priestly administrators (Kumor, 1969; Surdacki, 1992). The secular authorities were more than happy to provide such specialists.

Bearing the name of provisors, these representatives of municipal councils acted as hospital administrators with wide-ranging powers. Originally expected to exercise purely financial competencies, their functions soon grew quite extensive, including the responsibility not only for all that transpired within the walls of the hospital, but also for everything that even remotely touched upon the well-being of their institution. As the hospital's representatives in the outside world, provisors were necessarily responsible for the supply of provisions of all sorts such as food, firewood, furniture, apothecary materials, etc.; for the hiring and firing of the staff, for the admission and dismissal of inmates, for the care of the hospital buildings and inventory, including any livestock associated with the institution; finally they were responsible for the comfort and security

of the patients. They were the ones into whose hands alms-givers would place their gifts to the poor (Meczkowski, 1907; Góralski, 1963, 1982; Antosiewicz, 1966, 1978; Podgórska-Klawe, 1981; Rajman, 1992).

From the beginning of the fourteenth century, therefore, the vast majority of Polish hospital institutions were governed by what could be described as incipient Third Sector secular administration. The town councilors took their pretensions over hospital administration seriously, calling themselves protectors and controllers of such institutions in official city documents (Meczkowski, 1907; Wachholz, 1921).²

The Reformation, and its impact on the Reemergence of the Church in Matters of Hospital Governance.

Late sixteenth-century social and political events dictated a transformation of governance in the Polish hospital institutions. The power, prestige and wealth of urban centers decreased in the last decades of the century, and many hospitals shared in that decline. A number of factors, both foreign and domestic accounted for this retrograde movement. Constant invasions and depredations, such as the great Cossack uprising in Ukraine in 1648, the so-called Swedish ‘Deluge’ of 1655-60, and the Great Northern War of 1704-1721 ruined most Polish cities and depopulated the countryside by as much as a third.

The middle of the sixteenth century also saw great shifts in the Polish religious environment. The Reformation, originating in Germany following Luther’s nailing of the

² In the Kraków City Books under the date of January 23, 1466, the city councilors claim responsibility over Kraków’s largest hospital, that of the Holy Spirit: “Wir... Rathmanne iung und alt der Stad Cracow Bekennen offintlich mit disem briffe, das wir als vorwesir und vormunde des Spittels zum heligen Geiste...”

95 Theses to the castle church's door at Wittenberg, traced greater and greater circles, eventually seeping into Poland where it fell on fertile ground. Large segments of the nobility converted. With its Ukrainian lands predominantly Eastern Orthodox, the Bohemian borderlands open to Hussite penetration, and a considerable segment of its population Jewish, Poland already appeared used to a multi-religious experience. Just as the Reformation began to split the unity of Western Christendom asunder, the 1517 Constitution of Warsaw clearly stated that the monarch was a king of his subject's bodies, and not of their conscience. Roman Catholicism would remain the state religion of Poland, but it had to peacefully coexist with all other faiths. There were to be no religious wars in the Commonwealth.

In such an environment the leadership of the Counter-Reformation in Poland depended not on governmental actions to re-establish the pre-Luther religious situation but rather on the socially oriented features of the Catholic Church itself. Armed with a newfound mission following the Council of Trent (1545-63), the Church decided that one of the strategies to limit Protestant penetration would be to increase the Roman Catholic participation in and control of various social institutions. Hospitals were at the forefront of this strategy. They were thought of as institutions of Christian charity and Christian charity lay in the domain of the church. As an integral part of the religious establishment hospitals, just like all other spiritual institutions, were to be required to act as watchdogs over matters of faith. The spiritual well being of hospital inmates acquired greater importance than their material, or, for that matter, physical well being. By wresting control over hospital administration away from municipal councils, a lot of which were

quite susceptible to the new religious ideas coming in from Germany, the church attempted to limit the spread of Protestantism among the population.

This Counter-Reformation notion of restoring the unity of *Res Publica Christiana* by multiple means, including the reimposition of church controls over hospital governance, corresponds to many of today's ideas present in the concept of 'pooled governance' notions of non-governmental organizations operating within a Global civil society. In both cases the globalization (or European Catholicization, as in the case of Catholic Church's reentry into hospital administration) of institutional governance was meant to take a centrally defined strategy beyond local or regional matters and tout predominant common concerns. In both cases an intellectual or activist elite narrowly defined such common goals and interests. In both cases the normal operations of voluntary or NGO institutions were to be outright co-opted or rerouted towards those greater goals, often at the cost of absolutely overhauling or limiting the normal institutional activities.

In the case of pre-modern Polish hospitals, the 'think globally, act locally' call of some Green organizations of today was applied by the Catholic Church in a limited format of 'think Catholic, act Polish' common policy. The Europe-wide dictates promulgated at the Council of Trent and at the innumerable Polish ecclesiastical synods that followed in its wake reformatted hospital governance in a substantive, and long-lasting way. Hospitals, which until that very moment were thought of as civic not-for-profit institutions administered by lay officials, were co-opted away from the traditional modes of governance and became mobilized in a Pan-European social and religious struggle. Delegation of authority over hospitals from lay administrative units to the more

hierarchical ecclesiastical organs characterized this Polish reorientation of hospital institutional focus, where, in the end, the provision of health and social services became only an accidental function, and the preservation of Catholic spiritual health and well-being of the hospital patients became paramount.

The role of the hospital priest as a guardian of the faith intensified, as did his other responsibilities. A person who for whatever reason wished to enter a hospital would now have to identify himself or herself as a practicing Catholic, fluent in ritual and articles of the faith. With time the priest assumed a lot of administrative functions originally associated with the lay provisors, whose remaining responsibilities were further abridged by the Catholic Church's assumption of the role of hospital patron, and its replacement of the town council as the highest institution of hospital governance (Podgórska-Klawe, 1981).

The ecclesiastical establishment's preference for matters of the soul over those of body in terms of function and administration of hospitals at a time of Pan-European religious tribulations was clearly demonstrated by the reimposition of its notions that the care for one's soul overwhelmed in importance the care for one's body. According to the reemphasis of the spiritual aspects of social and health care provided by the hospital institutions in a post-Trent environment, a medical professional called to the side of a sick patient ought to immediately convince his charge that a doctor of faith should be called first, and any medical remedies ought to follow spiritual ones. The physician was also banned, under the pain of eternal damnation, to suggest to the patient any remedy that might jeopardize the soul, or to administer aid without a prior confession of his charge. These prescriptions, representative of ideas held by the church throughout the

centuries, formed an important part of the post-Trent offensive aimed at wresting control over hospitals from the lay authorities and imposing a holistic control mechanism over all aspects of hospital governance (Meczkowski, 1907; Surdacki, 1990).³

The Council of Trent itself took up the question of hospital governance during five different sessions, namely on the seventh (1547), fourteenth (1551), twenty-second (1562), twenty-fourth (1563), and twenty-fifth (1563). The most important conclusions reached strictly limited the centuries old administrative competencies of the lay provisors, basically reducing them to little more than ciphers. The local bishops, as the Church's representatives and leaders in this wide ranging campaign, were granted the authority to oversee all financial dealings conducted by the hospitals, as well as the authority to initiate periodic visitations of hospital institutions to make sure their operations conformed to newly imposed methods of governance; they were given the power to impose the requirement for hospital administrators to give yearly accounts of their work to the ecclesiastical authorities in the person of the bishops or their chosen representatives, the authority to initiate term limits of three years for remaining lay hospital administrators, and the power to confirm village hospitals under the jurisdiction of the parishes thus separating them from any attempts by the secular minded town council to enlarge their authority in the countryside. The bishops thus became final arbiters over hospital governance, organizing such institutions into what could be termed as sixteenth century versions of INGOs, their resources mobilized for the greater social and religious struggle (Meczkowski, 1907; Kumor, 1969; Podgórska-Klawe, 1981; Góralski, 1981; Surdacki, 1990).

³ Meczkowski mentions this prescription: "Ceterum autem, quum anima sit multo potior corpore, sub interminatione anathematis prohibemus, ne quis medicorum pro corporali salute aliquid aegroto suadeat, quod in animae periculum convertatur."

Following the dictates of the Council of Trent, Polish synods threw themselves into the fray. The chief issue noted time and time again by these local councils concerned the assumption of hospital governance by the ecclesiastical organs and the formulation of a Poland-wide strategy to promote, through the hospital institutions, the campaign against the spread of Protestantism in the lower rungs of society. The weapons employed by the church in their struggle against the secular provisors were mostly dependant on the church's spiritual authority. Councils of Wloclawek 1586, Plock 1593 and 1733, and Chelmno 1745, called on the provisors to subject themselves to the will of the bishops or suffer eternal punishment. Provincial Councils of Piotrków 1551 and 1557 reminded the bishops to take seriously their role as hospital overseers (Góralski, 1981; Surdacki, 1990). Councils of Wroclaw 1589, Wloclawek 1586 and 1589, Plock 1593 and 1733, Kraków 1601, 1621 and 1711, Przemysl 1636, Lvov 1641 and 1765, Poznan 1642 and 1738, and Chelmno 1745, reminded the provisors to give detailed accounts of their administrating practices and pecuniary policies to the bishops or their representatives, while the Councils of Kraków 1601, 1621 and 1711 Piotrków 1607, Warmia 1610, Przemysl 1636, Lvov 1641, Zmudz 1647 and 1752, Plock 1733, and Chelmno 1745, instructed the provisors on who to allow into their hospitals with a special admonition, made at the Councils of Warmia 1610, and Zmudz 1752, that all those accepted be spiritually sound, meaning fluent in the articles of Catholic faith, and finally, according to the Council of Poznan 1642, that the potential inmates be approved by the hospital priest who had a veto and final say on who should get in and who shouldn't (Wachholz, 1921; Antosiewicz, 1978; Surdacki, 1992).⁴ The Councils of Poznan 1642, and Kraków 1711,

⁴ Archiwum Kurii Metropolitalnej w Krakowie [The Archive of the Metropolitan Curia of Kraków], Acta visitationum... Jacobi Zadzik episcopi Cracoviensis 1638, A. Cap. Nr. 43. 310-318.

forbade the provisors to dispose of hospital property unless allowed to do so by ecclesiastical permission and, should the lay administrators be recalcitrant in their submission to the ecclesiastical organs, the Councils of Wloclawek 1589 and Przemysl 1636, gave bishops the authority to impose on them monetary sanction or even remove them from their posts. The 1642 Council of Poznan removed the election of the provisor from the municipal magistracy and transferred it into the hands of the local bishop, while reinforcing the administrative competencies of the parish priest in the countryside. The role of city councils in hospital governance was thus all but ended. When the ecclesiastically drafted Hospital Constitutions for the archdiocese of Poznan came into effect in 1672, lay provisors were clearly relegated to purely secondary positions behind the hospital priest, and their competencies were limited to helping the priest divide the acquired alms or to choosing an elder from among the poor to oversee internal cleanliness and peace (Meczkowski, 1907; Wachholz, 1921; Podgórska-Klawe, 1981; Góralski, 1982).

A wealth of prescriptive provisions could be culled from the synod's treatment of hospital patients. Moral considerations were afforded high importance on the list of councils' decrees. In order to prevent hospitals from becoming, as the synods termed it, hotbeds of immoral behavior, Councils of Kraków 1621 and 1711, Vilno 1710, Plock 1733, Chelmno 1745, and Zmudz 1752, put great stress on the separation of female from male inmates. The 1621 diocesan council of Kraków, in an article entitled *De Hospitalibus*, reinforced the need for hospitals to conduct religious practices on their premises (Kumor, 1969; Surdacki, 1990). Additionally, councils of Kraków 1621, Poznan 1642, Warmia 1726, Chelmno 1745, and Zmudz 1752, noted that all patients

were to be continuously screened for their knowledge of the dictates of faith. The hospital priests were to confess and give communion to every single new hospital inmate even before taking him or her to their bed. The Warmia Synod of 1610, for instance, forbade the admission of anyone without a prior examination of the knowledge of the articles of the Catholic faith. Thereafter, the patients were to be regularly confessed, and were to attend all masses performed at the hospital church, and spend their free time singing religious hymns and praying for the souls of their benefactors (Please see Table I). The 1672 *Hospital Constitutions* normalizing hospital inmate behavior for the archdiocese of Poznan remind one of stringent monastery regulations. The inmates were to be under constant religious supervision, were to attend regular confessions, be adequately enlightened about the Ten Commandments, and were to sing religious hymns three times a day. The hospital authority over their inmates was to be so unshakable that any foreign influence was categorically forbidden. The poor, according to the *Constitutions*, were to be denied the privilege of receiving visitors, even if such visitors were their own children, for fear of foreign religious ideologies penetrating inside the institutions (Glemma, 1947; Kumor, 1969; Góralski, 1963, 1982; Podgórska-Klawe, 1975, 1981; Karpinski, 1978; Surdacki, 1990).

The synodal interest in hospital administration after the Council of Trent was thus considerable (Please see Table II). Out of some 109 synods that took place in Poland in the seventeenth and eighteenth centuries, thirty-one concerned hospital governance (Wójcik, 1970, 1982).

The Catholic Church thus proceeded to normalize the internal life of the hospital inmates through the spiritual dictates of council edicts and synodal statutes, almost

entirely ignoring the material considerations of the people hospitals were designed to help in the first place. From the church's point of view, of course, the most meaningful services offered by the hospitals revolved around the provision of spiritual guidance. The sheltered poor, however, often gave very little attention to the salvation of their souls and were more concerned with their more earthly needs and necessities. As this apathy towards the reinforced religious aspects of their care became something of a chronic matter, hospital priests were often instructed by their ecclesiastical superiors to punish the most recalcitrant cases, or in the words of Kraków's Bishop Zadzik those *personae rudissimae et prima fidei principis ignorantes*.

In the Pastoral Letter of 1601, Cardinal Bernard Maciejowski, the Bishop of Kraków summed up these prevalent points about the poor in an appeal that "in order that the soul not to be ignored when one heals the body, the parson or chaplain should exhort them [hospital inmates] to have patience, and teach them things important to salvation. They should pray regularly and at least once a month, after confession, participate in the Holy Communion." The assumption *ut medicina spiritualis praecedat corporalem* explains both Kraków's Bishop Zadzik's 1638 admonition requiring hospital priests to lower the rations of those inmates most guilty of avoiding their religious instructions, as such "ingrates of God's Mercy were unworthy to consume hospital bread,"⁵ and Kiev's Bishop Zaluski's requirement to provide the sick patients first with a priest, and only later with a doctor. According to Zaluski's own 1762 Synod of Kiev, the primary responsibility of a physician lay in convincing the patient of the need for confession, and

⁵ Quoted in Meczkowski, "A gdzieby sie wtey mierze uporny który w tym znalazl, aby umknieniem porciey byl karany, gdyz taki niewdziecznik dobrodzieystwa Boskiego nie godzien zazywac chleba szpitalnego."

a refusal to undertake any treatment until presented with a priest-signed certificate of confession (Meczkowski, 1907).

The reassertion of ecclesiastical control did not, however, better the hospitals' conditions or even arrest the circumstances of their decline. During their time at the helm of hospital governance ecclesiastical authorities were more concerned with the institutional and legal aspects of the hospitals' subjection to the religious apparatus, rather than with the actual state of affairs on their premises. The hospital priests were also often incompetent or corrupt in administering the institutions under their care. Many opened themselves up to charges of advancing their own careers at the expense of the hospitals. Sumptuous living on the part of the higher clergy, who used hospital resources to support their lavish lifestyles and who considered hospitals and churches as nothing more than benefices created for their pleasure and enjoyment, devastated these institutions. A 1781 Episcopal visitation of a hospital in the city of Kazimierz nad Wisla ended with a sarcastic remark that the local hospital priest should stop eating bread for the next twenty-three years, as it is only fair that he who took bread away from the hospital poor and ate it himself, should fast as penance for his sins for the same amount of time. In the same year a similar visitation caught the priest of the hospital in the city of Urzędów in a scheme to limit as much as possible the number of poor sheltered in his hospital and to use all the received alms and most of the rents for his own purposes. In 1675 in the city of Kock the local priest abandoned his post and ran away, just a few weeks before a scheduled visitation, leaving the hospital to its own devices. Some hospital priests illegally sold hospital property, others took land for themselves, and utilized the poor housed within their hospitals as field hands. As early as 1554 a

provincial synod noted that even certain bishops, the supposed guardians of the integrity of hospital institutions, did not hand over alms slated for hospital maintenance but rather kept such sums for themselves. Many hospitals were thus turned into virtual benefices from which the priests and bishops derived gain, while the hospitals under their care, though at first they might have been well-endowed and in possession of considerable resources, were eventually turned into ruins, unable to offer more to their charges than the proverbial roof over their heads (Meczkowski, 1935, Góralski, 1982).⁶

In a curious and chronic way, when such abuses came to light, the clerical authorities usually defended even those most intransigent and very few hospital priests were actually punished. In the above examples, the same visitor who wrote such sarcastic comments about the priest in Kazimierz nad Wisla, defended the man by noting his abject poverty and insured his retention as the hospital priest for the next seven years. Only the priest of the Urzędów hospital met with censure, losing his administrative competencies to the lay provisors, though he retained his position as the spiritual leader of the hospital congregation (Góralski, 1982).

Well meaning bishops did note these abuses but the corrective and self-evaluatory statutes promulgated by Episcopal visitations and synods rarely found execution, as the local ecclesiastical authorities largely ignored most of them. Appropriation of hospital property by the ecclesiastical hierarchy or private individuals became more and more commonplace and pronounced as the social and legal relaxation of the Commonwealth continued undaunted. Falling hospital buildings in the villages were often expunged of the poor and taken up as places of residence or business. Elsewhere hospitals

⁶ Archiwum Kurii Biskupiej w Lublinie [The archive of the Episcopal curia in Lublin], księga wizytacyjna 1781 roku [The visitation book of year 1781], Nr. 105; księga wizytacyjna 1675 roku [The visitation book of year 1675], Nr. 99, k. 115v-116.

disappeared in their entirety, leaving only a grassy field where they once stood, and their remaining property such as lands and livestock passed on to the parish. Combined with the general political malaise and social disruptions accompanying the long agony of the Polish Commonwealth in the eighteenth century, these conditions brought Polish hospital institutions to the brink of collapse (Góralski, 1982).

Though the military operations conducted on Polish soil from the sixteenth to the eighteenth century did account for immense human losses and almost overwhelming social disruption, it is nevertheless unfortunate that the ecclesiastical apparatus, far less affected than the political, agrarian and municipal organs of the kingdom, found itself incapable of meeting the challenges faced, and unwilling to undertake more profound charitable initiatives than their transnational 'pooled governance' campaign during the time of the most pressing need.

Conclusions

The Reformation crisis altered irrevocably the prevalent practices regarding hospital governance in pre-modern Poland. Whereas before the Council of Trent, hospitals had established themselves as civic institutions filling the local needs of burgeoning urban communities, administered by lay officials with complete freedom of action to meet developing problems and to implement independent local policies, the advent of the Catholic Counter-Reformation erased these gains by imposing a stringent and single-minded governance that became detrimental to the quality of life hospital institutions offered to their charges. Hospitals, like other non-governmental charitable organizations of the time, were co-opted in the forefront of the developing Europe-wide

religious struggles. Their role as guardians of Catholic orthodoxy was supported by ecclesiastical council decrees that stressed their religious nature and emphasized the necessity of greater religious control over the lives of the patients. The process of admission into one of the institutions automatically conformed the new inmate to a whole new set of moral prescriptions and religious responsibilities. Towards the end of the sixteenth century hospitals became an arm of the Roman Catholic Counter-Reformation movement in Poland, barred to those of other faiths, and requiring a profession of faith, a confession, and continuous participation in religious practices on the part of the inmates. Their original function, to provide shelter to all sorts of sick and destitute, suffered as the local administrators lost their independence of action and had to subsume their operations within the wider, prescribed strategy of 'pooled governance'.

These developments, culled from the history of Eastern Europe's premier NGO institution, serve to remind all Third Sector researchers and practitioners working today that contemporary questions relevant to their interests do not exist in a historical vacuum; but rather what we learn about the past of NGO governance can strengthen our understanding of the factors that affect our ability to promote social change. Sixteenth and seventeenth century Polish hospitals could serve as a model of 'pooled governance' gone wrong, where the supra-national interests promoted actually retarded the ability of NGO institutions to meet their original stated goals of social care provision. Of considerable importance is also the failure of the ecclesiastically controlled institutions in pre-modern Poland to develop a coherent mechanism for implementing systemic changes based on viable self-evaluation. Implementation of today's transnational NGO strategies in Eastern Europe in general and Poland in particular could be made more secure by our

awareness of the difficulties accompanying past historical examples, especially those pertaining to the governance of pre-modern hospitals at a time of great social changes.

Table I

The spiritual responsibilities of the inmates in the Holy Spirit hospital of Przeworsk, in the Przemysl diocese, based on the 1755 visitation of Bishop Sierakowski.⁷

1. A special bell was to wake up the poor at four in the morning during spring and summer, and five in the morning during fall and winter. After waking up, in the fall and winter, all the poor were to march down to the hospital common room, and in spring and summer to the Church of the Holy Spirit, where, in Polish, priests were to read to them from spiritual works.
2. Afterwards the poor were responsible for the singing of one part of the Hail Mary rosary.
3. After the rosary they were to gather for an early Holy Mass in the parish church. They would walk there by twos, women at the front, men behind.
4. After the Holy Mass they were to return, in the same order, in the spring and summer to the Holy Ghost church, in the winter and fall to the hospital common room, and there, in front of the picture of the Holy Virgin, sing religious hymns, such as Welcome, Queen of Heavens, Of Shelter, and Be Blessed, Thou Holy Maiden.
5. The poor were to consume their dinner in a hypocaustum [a heated common room]. While dining they were to be read Saints' Lives. None of the poor could excuse themselves from the table before the conclusion of the day's reading.
6. After dinner all the poor were to go, by twos, to the Holy Spirit Church and sing The Angel's Blessing, and then, to honor the Most Holy Sacrament, they were to sing To You, Oh Lord, and Your Honor and Glory.
7. Then, in front of the Altar to the Holy Virgin, they were to sing The Litany to the Blessed Virgin Mary to receive a happy death, and, on Fridays, The Litany to the Name of Jesus.
8. At four in the afternoon, or later, and depending on the time of year either in the common room or in church, they were to sing The Crown, and later To You, Oh Lord, Jesus Fainting in Gethsemane, and also to St. Joseph, Happy, who himself Joseph.
9. After supper they were to repeat all that they had done after dinner, with the addition of singing Angelus.
10. Then, during the next half an hour, they were to be read spiritual texts, to which the poor were to listen while on their knees, with the Crucifix in front of them. Before going to bed they were to take account of their conscience.
11. The poor were to attend, by twos, the special early mass of the Holiest of Holy, known as the privileged mass, performed at the Przeworsk parish church throughout the year on Thursdays.

⁷ Archiwum Diecezjalne w Przemyslu [The diocesan archive of Przemysl] Wizytacja Sierakowskiego, 1755 [The Sierakowski visitation of 1755], 32v.

Table II

A list of issues relating to hospital governance raised during the sessions of Polish ecclesiastical councils following the Council of Trent.

Synodal Council	Hospital-related Issues Raised
1586 Wloclawek-Pomorze	Ecclesiastical responsibility for hospital property.
1589 Wloclawek	Ecclesiastical responsibility for hospital property.
1593 Plock	Ecclesiastical responsibility for hospital property.
1601 Kraków	Cardinal Maciejowski's <i>De iuvandis pauperibus</i> (necessity of fair and honorable governance by provisors, accountability of provisors, admittance practices, turning out of 'false' poor from the hospitals), ecclesiastical responsibility for hospital property, new hospital foundations.
1604 Chelm	Hospital administration, ecclesiastical responsibility for hospital property.
1607 Piotrków	<i>De iuvandis pauperibus</i> , Cardinal Maciejowski's <i>Epistola pastoralis</i> (separation of sick from healthy, separation of men from women, importance of performing religious practices, call for family members to visit their dear at the hospital, accountability of provisors, hospital administration, admittance practices, turning out of 'false' poor from the hospital), ecclesiastical responsibility for hospital property.
1610 Warmia	<i>Epistola pastoralis</i> , hospital administration, accountability of provisors, importance of religious practices, admittance practices, ecclesiastical responsibility for hospital property.
1620 Gniezno	New hospital foundations.
1620 Wloclawek	New hospital foundations.
1621 Kraków	<i>De Hospitalibus</i> (Hospitals should not admit more poor than their resources allow, importance of religious practices, patients ought to leave the hospital once healed, statutes for begging by hospital poor), <i>De iuvandis pauperibus</i> , ecclesiastical responsibility for hospital property.
1621 Przemyśl	<i>Epistola pastoralis</i> .
1624 Chelm	Hospital administration, importance of religious practices, fair governance of provisors, <i>Epistola pastoralis</i> , ecclesiastical responsibility for hospital property.

Synodal Council	Hospital-related Issues Raised
1628 Gniezno	<i>Epistola pastoralis</i> , questionnaire for hospital visitations, new hospital foundations.
1628 Chelmno	<i>Epistola pastoralis</i> , new hospital foundations.
1634 Wloclawek	<i>Epistola pastoralis</i> , new hospital foundations.
1636 Przemysl	Accountability of provisors, hospital administration, fair governance of provisors, <i>De iuvandis pauperibus</i> , ecclesiastical responsibility for hospital property, admittance practices, turning out of 'false' poor from the hospital.
1639 Zmudz	Questionnaire for hospital visitations.
1641 Chelmno	<i>Epistola pastoralis</i> .
1641 Lvov	Hospital administration, accountability of provisors, ecclesiastical responsibility for hospital property, admittance practices, turning out of 'false' poor from the hospital.
1641 Wloclawek	New hospital foundations.
1642 Poznan	New hospital foundations, accountability of provisors, fair governance, importance of religious services, internal hospital discipline; ecclesiastical responsibility for hospital property.
1643 Gniezno	New hospital foundations.
1647 Zmudz	Admittance practices, turning out of 'false' poor from the hospital, new hospital foundations.
1689 Poznan (diocesan)	Accountability of provisors and provosts.
1711 Kraków	Vagabondage, hospital administration, hospitals should not admit more poor than their resources allow, importance of religious practices, separation of men from women, statutes for begging by hospital poor, admission practices, turning out of 'false' poor from the hospital, accountability of provisors, support for those poor not housed in the hospital; ecclesiastical responsibility for hospital property.
1717 Chelmno	<i>Epistola pastoralis</i> .
1717 Vilno	Bishop Pac's <i>Modus et Ordo Boni Regiminis in Diocesim Vlnensem</i> (Hospital administration, accountability of provisors, fair governance by provisors, separation of sick from the healthy, separation of men from women, admittance practices), separation of men from women.
1720 Gniezno	New hospital foundations, ecclesiastical responsibility for hospital property.

Synodal Council	Hospital-related Issues Raised
1720 Poznan	New hospital foundations, survey of hospitals in the Poznan diocese, ecclesiastical responsibility for hospital property.
1720 Zamosc	Questionnaire for hospital visitations.
1723 Przemysl	Hospital the beneficiary or monetary fines placed on clergy.
1726 Luków	Hospital administration, fair governance, specific pauper issues (orphaned girls), ecclesiastical responsibility for hospital property.
1726 Warmia	Hospital administration, importance of religious practices.
1733 Plock	Hospital administration, separation of men from women, internal hospital discipline, importance of religious practices, fair governance, admittance practices, turning out of 'false' poor from the hospital, ecclesiastical responsibility for hospital property.
1745 Chelmno	Hospital administration, hospitals should not admit more poor than their resources allow, importance of religious practices, separation of men from women, statutes for begging by hospital poor, admission practices, turning out of 'false' poor from the hospital, accountability of provisors, ecclesiastical responsibility for hospital property.
1752 Zmudz	Importance of religious practices, admission practices, turning out of 'false' poor from the hospital, ecclesiastical responsibility for hospital property, new hospital foundations.
1762 Kiev	Statutes for begging by hospital poor, importance of religious practices, questionnaire for hospital visitations.
1765 Lvov	Importance of religious practices, new hospital foundations, accountability of provisors, ecclesiastical responsibility for hospital property.

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