

【연구논문】

# Heterotopic Landscape in Antebellum Charleston, South Carolina\*

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## 1. Introduction

When journalist James Redpath traveled to Charleston, South Carolina, in the 1850s, he declared his stay there “one of the happiest periods of my life.” He was fond of Charleston’s old customs, “thoroughly English appearance and construction,” and “genial climate.” Soon Redpath became disgusted with the disguised manifestations of hatred including a jail in the “Scotch Presbyterian style of architecture” and the “Sugar House” [the work house] in a massive building resembling a feudal castle” (50-51). Similarly, Scotsman Adam Hodgson recognized the incongruous “mixture of gaiety and splendor with misery and degradation.” He recalled the contrasts between the “delicate pink peach-blossoms which surround

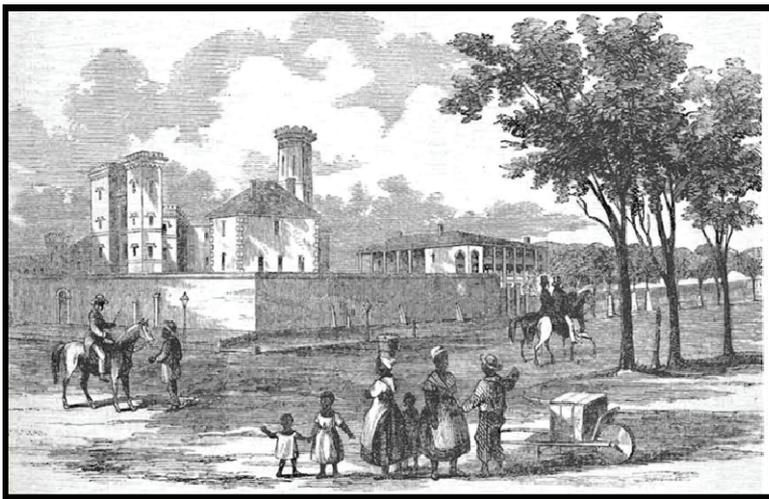
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the black hovels of slaves on the plantation” (124-125). Most visitors to Charleston including Redpath and Hodgson found Charleston to be a city of contradictions between its appearance of picturesque refinement and genteel hospitality and its contiguous “gloomy, uneasy scenes.”

In Charleston, the gloomy, uneasy scenes of the city were collectively located in a single square block formed by Queen, Mazyck (later, Logan), Franklin, and Magazine Streets (see fig. 1). This collection of the “darker” side in society—this square block—was reserved by Charleston’s colonial government for public purposes as early as 1680, when it converged at a square that covered two acres (60 feet wide) and a public wharf (also 60 feet wide) laid out along the Cooper River (Fraser 1-13). By the mid-nineteenth century, the buildings—the Jail, Poor House, Work House, Marine Hospital, Medical College of South Carolina, and Roper Hospital—had been constructed there to regulate Charleston’s socio-politically less desirable and marginalized populations, such as slaves, prisoners, workers, and the sick. Geographically, this deliberately planned space was located a short distance from the city’s two main streets, Broad and Meeting (see fig. 2 and 3). It was also situated on less desirable, poorly drained plots, north of Queen Street in the center of the Charleston Peninsula. Among the six buildings in this block, half of them—one medical school and two hospitals—served solely for medical care and education, and the other three even had their own medical units for their inmates. Additionally, a block or so down from the square, one more medical school—the Medical College of the State of South Carolina—operated until 1838. The buildings in

this single square block thus formed their own distinctive medical landscape in antebellum Charleston. Because this characteristically public block was separated from other parts of the streets and the other part of the city, society's "brighter" side was brighter and even healthier.



<Figure 1> Charleston's Public Building Complex

Work House (to the left), Jail (middle), and Marine Hospital (to the right)  
Source: *Ballou's Pictorial Drawing-Room Companion*, 8 August 1857.

The primary aim of this study is to examine the public buildings block in antebellum Charleston in the spatial context. Spatial studies scholars like Henri Lefebvre (1991) and Edward Soja (1989, 1996) argued that space has never been a scientific object removed from ideology and politics, rather it has always been political and strategic. In addition, they stated that space is also integral and salient in

forming a group (or class) consciousness in a society. These scholars argued that the social production of space is commanded by a ruling class as a tool to reproduce its dominance. Buildings and built environments were the material settings in which Charlestonians defined their identities and understood their sense of place. In particular, Charleston's public building complex is a distinctive example of Foucault's notion of *heterotopias*.

The term *heterotopia* is a combination of two Greek words, *hetero* (meaning the other) and *topia* (meaning place). Although Foucault never explicitly referred to it, *heterotopia* is originally a medical term to identify those heterogeneous organic conditions that present either heterogenous or heterogenic composition of abnormality in structure, arrangement, or manner of formation, without affecting the normal functioning of the overall organism (13-29). In *Dictionary of Human Geology* (2000), similar to the medical definition, heterotopia is defined as "sites where the incongruous and incommensurable are brought together in tense, unsettling and, often, transgressive juxtapositions" (Johnson et al. s.v.). As German scholar Sigurd Lax stated, medicine and architecture are comparable disciplines due to the analogy of organisms and structures and the inner functioning of a city or an edifice (qtd. in Sohn 43). However, unlike medical heterotopia, Foucault's heterotopia has disturbing functions in that it can overturn established social orders or can be a reflection of the underbelly side of society. Therefore, Foucault's heterotopia is similar to a counter-site or "enacted utopia" that simultaneously challenges and inverts *real*, present place. Heterotopia is thus used as the conceptualization and exceptionality of a single real place where

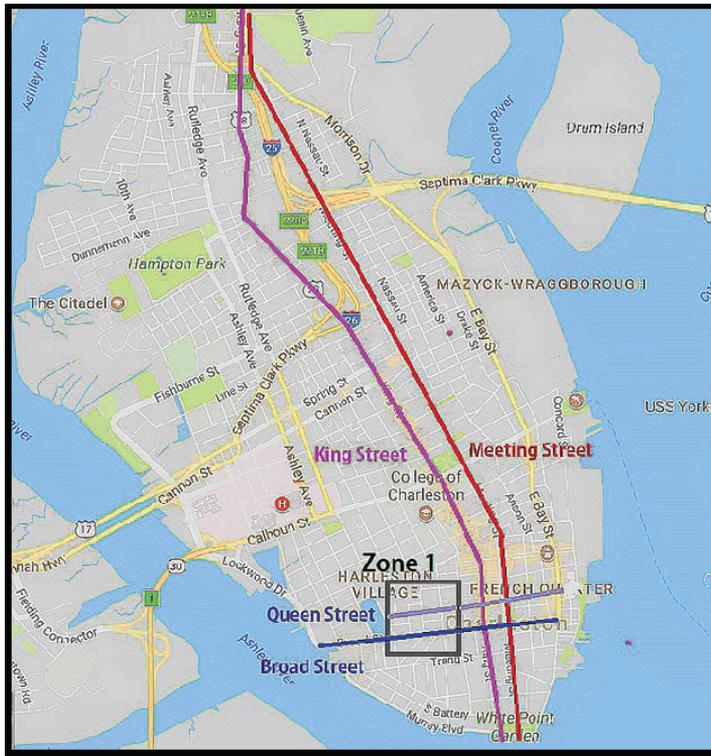
several sites and social groups are in themselves incompatible, but which helps to maintain the city's stability. Foucault argued that almost every culture has made one of two major heterotopias: one of crisis or one of deviation. Foucault classified various sites of heterotopias in relation to: 1) crisis (honeymoon destinations, boarding schools); 2) deviance (psychiatric hospitals, rest homes, prisons, jails); 3) function (cemeteries); 4) the juxtaposition of different spaces (cinemas, gardens, carpets); 5) the concept of *heterochronia* (accumulation of time—museums, libraries, holiday villages, festivals); 6) inclusion and exclusion (barracks, Scandinavian saunas, motels); and 7) in-betweens (colonies, brothels, ships). (18-22). Among Foucault's heterotopias, a one-block-street included a variety of forms of heterotopias reflecting different aims of the society—Poor House, Jail, Work House, Marine Hospital, Medical College of South Carolina, and Roper Hospital.

Through the lens of heterotopias, the story of Charleston's public building block reveals the ways which the colorful social and cultural fabric was woven by both desirable and undesirable layers of threads. It should be noted that many scholars have observed, the concept of heterotopias is vague and controversial. Because of this vagueness, however, the concept opens up unexpected possibilities for exploring multiple issues without the burden of theoretical and conceptual constraints. In this sense, I wisely adopt social scientists Derek Hook and Michel Vrdojak's usage of heterotopias, as a "pragmatic, instrumental, and conditional tool," in order to propose some conjectural links between identity, power, and place, rather than as a rigid framework that confines research boundaries (76-77). Even

though I rely on some cultural theories and frameworks in this study, I do not intend to engage with theorization or generalization of historical events. Instead, given both the abundance and quality of the relevant historical evidences, this study is in a strong position to drive forward historical reevaluations and new interpretations of the heterotopic geography of antebellum Charleston.

## **2. Segregated Cityscape in Charleston**

James Silk Buckingham was impressed on his trip to Charleston, finding it to be a densely built and compartmentalized city, with “tolerable regularity,” whose streets were laid at roughly right angles to one another (47). As Buckingham recognized, Charleston was fitted with grids to define space in easily legible ways. As early as since the colonial period, the grid was extensively used as the basic foundation in a number of American cities. Each of these cities including Charleston adopted in the grid with their own purposes (Upton Part II; Peterson xv, 5-18, esp. 9-10). Charlestonians utilized the gridiron plan in which streets ran at right angles to each other, in order to separate and categorize people and the daily life of a city according to its natural and living surroundings.



<Figure 2> Charleston Map

Source: "Charleston, SC." *Google Maps*. Retrieved on 1 May 2017.

Charleston is bounded on the west and south by the Ashley River, on the east by the Cooper River and on the southeast by a harbor almost completely land-locked from the Atlantic Ocean. It is located in a narrow valley in the western Appalachian Mountains at the junction of the Kanawha and Elk rivers. A chain of barrier islands between Charleston's mainland and the Atlantic Ocean adds sandy beaches and marshland to the region's geography. Even though

Charleston's proximity to the Atlantic Ocean provides a temperate climate, its weather is highly changeable, particularly during the winter months when Arctic air may alternate with tropical air. Spring temperatures warm rapidly, and summers are occasionally hot and humid. The summer is Charleston's rainiest season with over 40% of its annual rainfall occurring in the form of thundershowers and the occasional tropical storm. Hurricanes threaten in late summer and early fall. In the summer, sea breezes cool the city to a temperature of about three degrees below the higher country. During the winter months, the temperatures on the peninsula are often warmer than inland because of the ocean's influence. In winter, however, sharp temperature contrasts are the rule—even on a day-to-day basis—and total annual snowfall ranges from less than 5 inches to more than 50.<sup>1)</sup>

Historians like Maurie D. McNinnis argued that because of Charleston's distinctive geography and weather, the city was divided into desirable and less desirable lands (McNinnis). Even though the desirable land was mostly determined by the natural surroundings, that space was firmly established by class division. During the antebellum period, Charleston underwent a transition from an "open" to a "closed" city. The fluid social structure of the eighteenth century was transformed into a more rigid social hierarchy (McNinnis 8;

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1) Beginning in 1828 every issue of *Charleston Medical Journal and Review* included metrological information and physicians' observation on the relation between the weather and disease, especially, yellow fever. In 1842, Charleston physicians appointed a special committee to take into consideration the practicability of establishing an inter-state meeting and communication among physicians for the purpose of obtaining information related to meteorology and diseases from other parts of the state (Waring, *Excerpts* "June 1<sup>st</sup> 1824" and "August 1<sup>st</sup> 1842").

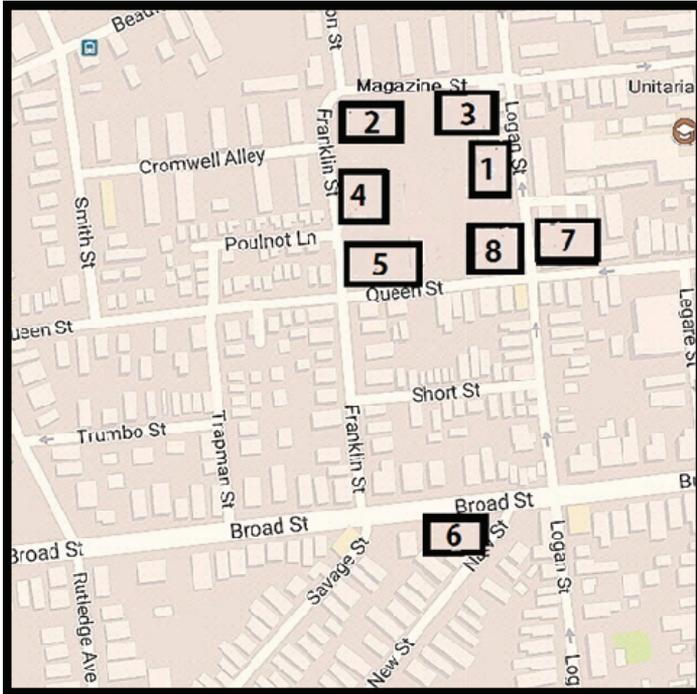
Rogers 26-54, 141-166). As northern visitor Louis Fitzgerald Tasistro noticed, Charleston was distinctly marked by “the gradations in the great social system.” Tasistro identified three groups of the upper class: the mercantile, the literary, and the aristocratic. Through either economic success or political power, the mercantile and literary classes were part of Charleston’s elites. Depending on their familial ties, only some of them might have been part of the aristocracy (116-117). Most of Charleston’s aristocracy comprised planters and their families, who had at least some planting interests and over half of whom owned large plantations. McInnis emphasized the importance of the rigid class boundary in Charleston society by denouncing Michael O’Brien’s notion of fluid social order in the antebellum South (McInnis 24, 336); O’Brien argued that the social order was more fluid in the South and that wealth was really what mattered and even the notion of the “planter class” was largely a postbellum phenomenon (364-378). Many scholars also argued that even though Charleston was a multilayered society with many different economic and social levels, upward social mobility even from the middle to the upper class was rare (Pease and Pease, “Social Structure” 117-118). By using the 1860 census, historian Michael P. Johnson also examined the distribution of wealth using each of the 4,644 households as economic units. He also found that the top 1% of the population owned 27% of the city’s wealth and the top 10% controlled over 75% of it (65-80). Throughout the antebellum period, the top 4% of the population controlled more than 50% of the city’s wealth, whereas the bottom 50% of the free population did not own any wealth or slaves (Pease and Pease, *The Web of Progress* 236).

Because of Charleston's distinctive geography and weather, the city was divided by "desirable" and "less desirable" lands, even though the city's physical geography was diverse. As noted earlier, Charleston is bounded on the two rivers (Ashley and Cooper Rivers), and by the Atlantic Ocean. Some lots on the Charleston Peninsula comprised low-lying marshland and the humidity of the land was thought to be insalubrious and unhealthy. The "desirable land" was thus mostly determined by geography. The "desirable" parts of the city were those on solid, high ground that experienced sea breezes. Most of the wealthy class built their homes in the "desirable" sections of the city, which were close to the sea and located in the city's peripheries. The Meeting and Queen Streets were the most prestigious places in Charleston. Along these two streets, most of the houses were densely built and the public and residential structures were mixed. On contrary, the "less desirable, poorly drained plots" were located inland of the city and north of Queen Street and were left for the less affluent groups, such as shopkeepers, merchants, artisans, and the lower classes (McInnis 52-5, 339nn28-29). When comparing Charleston and Boston, historians William H. Pease and Jane H. Pease noted that Charlestonians did not "cluster" either by class or function as much as Bostonians did. It was common, however, for storekeepers to live above their shops on King Street, for merchants to live on the east side closer to the wharves and for the city's laborers to live north of Queen Street in the city or north of Boundary (Calhoun) Street (Pease and Pease, *The Web of Progress* 9, 267n13). When, during the yellow fever epidemics, Charleston physicians recorded the location that the first or multiple patients

were discovered, there were recorded patients from the residence area near King Street: a seaman named Schwacter became a victim of yellow fever, while staying in the lower part of King Street. While residing on King Street near Broad Street, Irishman Abbot was calling a physician for medical attention for yellow fever. A black laborer living in Broad Street, between Meeting and King Streets was recorded as the fifth victim of the 1858 yellow fever (Hume 11-12; Dawson, "Report of Cure of Yellow Fever" 693; Dawson, "Editorial and Miscellaneous" 843). Since the "less desirable" residential areas were thus unhealthy, disease-prone, public medical institutions including Poor House (and its Hospital) and Roper Hospital were located on the streets two blocks away from King Street and right on Queen Street (see fig. 2).

In sum, in order to maintain the health of the city, Charleston confronted two—natural and urban—challenges. The issues of the city's survival and prosperity had to be clarified in order to answer the question of how natural challenges—sub-tropical weathers and diseases, and maritime environments—could be lessened or removed by and within the urban solutions and setting. One of the city's solutions was segregation of the public space by intentionally enacting heterotopias. Charleston's heterotopias explained various institutions and social places that interrupted the continuous, normal conditions of everyday life. However, they did not completely deny the normality of everyday life; rather, they showed the social, cultural, and political layers of the tensions between normal or desirable and abnormal or undesirable life in Charleston's built environment.

### 3. Charleston's Heterotopic Environments



<Figure 3> Zone 1 Close-up

\* Directory

1. Poor House (later, Work House)
2. Jail
3. Work House
4. Marine Hospital
5. Medical College of South Carolina (1826–1838; after 1838, Medical College of the State of South Carolina)
6. Medical College of the State of South Carolina until 1838 (“Old Theater”)
7. Catholic Orphan House
8. Roper Hospital

Heterotopias resist uniformity. Charleston's contrasting street scenes—embracing both English, aristocratic, white, elite culture and gloomy slave and working-class lives—converged into the single public building complex. Here, the juxtaposition of the two scenes—dark and bright—mapped out the fusion of “troubling dualisms” of life and death, good and bad, health and illness, and the ruling and ruled classes. This congregated space of heterotopias created new conceptual spaces and shaped alternative orderings that challenged the boundaries traditionally conceived to separate the social dimensions of daily life.

### **Gloomy Charleston**

As a writer in *Charleston Courier* noted, the city was the place “where from the very denseness of population and closely contiguous settlements, some more energetic and scrutinizing system [was] absolutely *necessary*” (22 Sept. 1845). The notion of a more energetic and scrutinizing system was embodied in the “darkest sides” of the public building complex, particularly the Poor House, Jail, and Work House. In addition, even though the presence of the Marine Hospital reflected a somewhat different perspective, it had still part of Charleston's “undesirable elements”; it represented the federal authority threatening state sovereignty—the major southern political ideology during the antebellum period. In some sense, the “gloomy parts of Charleston” was a heterotopian space of deviation—poverty, crime, disease or any other aspect of disorder.

As a commercial city, Charleston had few districts where only one racial, ethnic, or economic group lived and worked together. The

city's commitment to a dual society of whites and blacks generated distinctively southern political, social, cultural, and medical values. The city's racial and ethnic composition and the politics of race generated a bonded labor system and shaped the distinctive social patterns that differentiated most southern cities from northern ones. The high visibility of black people was one of the distinctive marks of southern urbanism. Charleston's black population remained over 50% of the total population between 1830 and 1850 (see table 1). In 1850, Swedish traveler Fredrika Bremer (1801-1865) visited Charleston and claimed, "Negroes swarm the streets. Two-thirds of the people whom one sees in town are negroes or mulattoes. They are ugly, but appear for the most part cheerful and well fed" (Bremer 264). Even though her estimate was exaggerated regarding the number of blacks living in Charleston, their vivid presence in the city's street life was sufficiently impressive.

In addition to African-Americans, the influx of foreign-born immigrants made Charleston more racially and ethnically diverse. During the 1830s and the 1860s, Irish and German working-class immigrants flooded into Charleston, seeking jobs as domestic servants and competing with free blacks and slaves (Fraser 237). By the mid-1850s, approximately 40% of the white population of nearly 9,000 were Irish or German immigrants, who comprised two-fifths of the working-class population: Charleston, therefore, had almost the same percentage of foreign-born citizens as many northern cities (Bellows 162n5; see table 1).

**<Table 1> Charleston’s Population, 1830-1860, Showing the Racial Composition**

YEAR	TOTAL	WHITE (PERCENTAGE)	BLACK (PERCENTAGE)			NATIONAL URBAN POPULATION RANK
			SLAVE	FREE	TOTAL	
1830	30,289	42,3	50,7	7,0	57,7	6
1840	29,261	44,5	50,1	5,4	55,5	10
1850	42,985	46,6	45,4	8,0	53,4	15
1860	40,522	57,7	34,3	8,0	42,3	22

Source: (adapt. Coclanis 115; Gibson)

In 1738, much earlier than the 1850s when the foreign-born poor flooded into Charleston, the first Poor House was founded. Public relief for the poor began in 1698 when an act of the Provincial Assembly provided for levying a poor tax to supplement the inadequacies of private charity. By an Act of Assembly in 1712, two commissioners elected from the Parish of St. Philip, together with the churchwardens of the parish, were charged with taking measures for the succor of the poor. In 1736, the parish secured the passage of an act that authorized erecting a hospital, a work house, and a corrections facility for “paupers, vagrants and common beggars.” Before the first Poor House was built, personal benevolence was the primary source for taking care of “vagrant and idle persons.” Because the pauper and the criminal blurred together in the eighteenth-century public mind, the Poor House soon functioned as both a jail and a public relief house. On April 12, 1768, due to the increases in the poor population, the Commissioners of the Exchange and Custom House were authorized to erect a Poor House and its Hospital. In early 1768, “Act for appropriating the presenting the present Work House for a place of Correction···and for building a Poor House and

Hospital” was passed. On Charleston’s western fringe were a public powder magazine, the old barracks, and the old Poor House and Hospital. By 1770, the second Poor House and its Hospital were built on Mazyck (Logan) Street and Magazine Street in the public building complex block, solely for the welfare of the poor (see fig. 3, no. 1). The old Poor House and Hospital were to be used solely as places of confinement and correction for fugitive slaves, seamen, and “vagrants, idle, intemperate, and vicious persons.” The old Poor House, therefore, replaced the Work House and its Hospital, which had been used as an infirmary for the homeless sick as well as the House of Correction since 1734 (*Roper Hospital Board of Trustee Minutes* July 24<sup>th</sup> 1855; Fraser 117-118; Bellows 5-7, 17-9, 74). By the mid-19<sup>th</sup> century, as the Commissioners of the Poor thus urged the city government to improve the inmates’ living conditions, the city purchased a building from the Charleston Factory Company on Columbus Street, between Drake and Court Streets to serve as the city’s new Almshouse [later, renamed as the Charleston Home] (Fraser 193-194, 237). The old Poor House building reverted to use by free blacks, who had lived in rooms of the Work House that had been fitted out for them in 1842. The larger building became necessary due to large-scale foreign immigration beginning in the 1840s (Bellows 164, 67-74). In the summer of 1838, when Mayor Henry L. Pinckney (1794-1863) inquired after the condition of the Poor House, the report said that 279 non-Charleston natives had passed through the asylum, compared with 24 local poor, and that 168 patients had been treated in the past ten months (Bellows 76). During the years of 1850-1856, the number of inmates in the Poor

House rose from 691 to 1,363 and the ratio of foreign-born to native inmates reached seven to one (Fraser 235-236).

While the Poor House functioned as a refuge for the socially and economically marginalized group of people, two buildings that scared James Redpath—the Jail and the Work House (see fig. 3 nos. 2 and 3)—were part of the actual and symbolic regulation of the behavior of urban unruly groups whether white or black. The Jail was constructed on Magazine Street within this public square block as early as 1802 and was used until 1939. In 1822, the four-story Jail had a two-story octagonal tower and a fireproof wing with individual cells. In 1855, the rear octagonal wing was expanded, and the Romanesque Revival style was used to provide the building's details (Mills 239). The Work House was set up for the “confinement and punishment of slaves.” Before the Vesey insurrection, slave owners could send their slaves to the Work House to be whipped for a cost of 25 cents per trip. In 1825, after the insurrection, an additional manner of punishment was added to the Work House, the “tread-mill,” which was designed to force slaves to walk for eight hours a day, three minutes on and three minutes off. An editorial of *Charleston Mercury and Morning Advertiser* recommended the “Stepping Mill” (treadmill) to female slave owners, “whose humanity too often stands between the Negro and the well-merited visit to the Work-House.” There they would find in “this excellent invention” an alternative to whipping (“A City Rustic”; Steffen 770).<sup>2</sup> As Robert Mills (1781—1855)—one of the first American-born professional

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2) Historian Richard C. Wade also addressed the “stepping mill” in his book, but referred to incorrect information (96, 191-2, 301, 313).

architects—explained, the treadmill was intended to benefit many slave owners. He argued that the slave owners “heretofore have been often induced to pass over faults in their slaves [de-meriting] correction, rather than resort to coercive measure with them, who now will, without doing violence to their feelings, be able to break their idle habits, and subject them to a discipline that promises, morally, as well as physically, to be beneficial to them” (420-421).

In addition to these three conventional forms of heterotopias of deviance, Charleston had a unique institution of deviance, the Marine Hospital (see fig. 3, no. 4). The history of the Marine Hospital in Charleston was the city’s struggle against any federal authority. The federal government had attempted to build up a governing power over the sick seamen throughout the nation, even though during the antebellum period, its influence was minimal and limited in Charleston. The fact that governing the Marine Hospital was the federal government’s responsibility was quite disturbing to Charlestonians. In 1802, the Secretary of the United States Treasury proposed that the city government had to take charge of the sick seamen, but Charleston had established a Marine Hospital as early as 1749. Its building was initially established as St. Philip’s Parish Hospital in 1736, although by 1833 it was managed by the City Council.<sup>3)</sup> The city council made a resolution to confirm that the care of sick and disabled seamen belonged “essentially to the General [federal] Government” and not to the city of Charleston. They then

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3) St. Philip’s Hospital was eventually enlarged and then replaced by what became known as the City Hospital—the former Poor House Hospital in Mazyck Street (Waring, *Roper Hospital* 3).

asked the Congress and the federal government to provide them with a fixed annual appropriation for the hospital or more funding amounting in the aggregate to upward of \$50,000 to support the hospital. Without such additional funding from the federal government, the city council declared that Charleston would relinquish all connection with and all future management of the Marine Hospital (*Daily National Journal*). By 1830, Congress at last provided funding to build a new building. This particular building construction started in 1831 and was completed in 1833 in the public building complex (McInnis 32, 93, 219-22, 229-30). Subsequently, Charleston's public complex unveiled the issues of federal governmental intervention and national public health concerns, especially the health of seamen, this important demographic being the foundation of the nation's wealth during the mercantilist period. Even though its influence on southern health care was weak and unorganized as a whole, the presence of the Marine Hospital reveals a diverse social spectrum of health care in Charleston.

In sum, the above-discussed four institutions—Poor House, Jail, Work House, and Marine Hospital—formed the areas of the city's shaded regions. These institutions were reserved to keep the city healthy and prosperous. In the same street block, such concerns for the wellness of the city were embodied in the Medical College of South Carolina and Roper Hospital as different forms of heterotopias. This story of congregated heterotopias brought about a multi-layered understanding of spaces, arguing that a holistic understanding of the urban landscape must look beyond the physical place of community buildings.

### **The Southern Ideals**

The first building of the Medical College of South Carolina was built at the corner of Queen and Franklin Streets in 1826. The building was designed by Frederick Wesner. With a rhythmic spacing of six Ionic pilasters across the façade and a projecting Ionic colonnade in the center, this two-story, roughcast, brick building was more closely related to the Palladian classicism of the courthouse than the monumental classicism of Robert Mills' First Baptist Church or the Fireproof Building. As a result, Wesner's building affirmed the local commitment to the future as one bound to the past. As with the arsenal, it emerged from a period of self-reflection and inquiry before the Nullification Crisis hardened Charleston's political stance into an aggressive posture (McInnis 98).

Charleston, as a great seaport and trading market, was one of the starting points of drastic outbreaks of epidemic diseases and, consequently, also one of the centers of the ideology of "southern states' rights medicine." In addition, the city's low-lying, semi-tropical geographic conditions made the danger of illness a constant fear; dysentery, malaria, yellow fever, cholera, and scarlet fever weakened Charlestonians, and in particular, yellow fever caused the most dramatic mortality. Between 1800 and 1860, 25 major yellow fever epidemics occurred in Charleston, and between 1821 and 1858, yellow fever caused almost twice as many deaths as all other epidemic diseases combined—a total of 2,943 compared with 1,759 from the other diseases. During the drastic yellow fever epidemics in 1853, about 18% of the city's residents died (Fraser 189; Waring, *A History of Medicine in South Carolina* 30; Humphreys 5). In addition

to the constant threats of semi-tropical epidemics, as mentioned earlier, the Nullification Crisis of 1832 not only affected each state's political agendas but also provoked heated passion on the rhetoric of distinctively southern medicine at both the local and national levels. From the early 1830s onward, Charleston physicians pointed to a variety of factors that distinguished the South's medical character from the character of other regions and that dictated modifying the medical knowledge and practices that were appropriate elsewhere. When Charleston physicians attempted to build their own, locally based medical school—the Medical College of South Carolina (see fig. 3, no. 5)—the ideology of southern medicine was elaborately discussed.

The opening date of Charleston's Medical College of South Carolina (now the Medical University of South Carolina)—1824—marked a significant moment in the history of medicine in the Deep South.<sup>4</sup>) In 1829, Charlestonians took pride in their “most excellent and flourishing” medical school, stating “we do not fear to repeat... that a better Medical Education, especially for Southern Students, is not to be found in the United States, than in our own College in this city” (*Raleigh Register*). Because Charleston physicians had a stronger sense of their region than any other places, they utilized the idea of “a Southern Education for Southrons” during the years that Charleston's medical wing was split over the issue of governing the medical school between the faculty and the Medical Society of South

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4) The first medical college in the South was the College of Medicine of Maryland, Baltimore, Maryland, in 1807. This was also the first public medical school to open its own teaching hospital in 1823 (Sewell chapter 4).

Carolina; in fact, the physicians ultimately operated two medical schools. From 1833 to 1838 when the two schools—Medical College of South Carolina and Medical College of the State of South Carolina—were merged, these two schools waged an ideological war over who would take the control of the school as well as a conflict of regionalism. In 1833, Drs. Frost, Ravenel, Prioleau, Holbrook, and Wagner resigned professorship at the Medical College of South Carolina and moved to the new school, Medical College of the State of South Carolina (Pease and Pease, *The Web of Progress* 233-254). Four out of six professors were brought from northern cities: Drs. John. R. Rhineland of New York (anatomy), G.S. Bedford of New York (obstetrics), William Anderson of Philadelphia (surgery), and Charles Davis of Philadelphia (chemistry); the other professors were Andrew Hasell (materia medica) and Henry Alexander (Institute of Medicine), both of Charleston. Particularly, Dr. John Rhineland, the professor of anatomy—anatomy as the field considered as a distinctive “southern” element with regard to race—was from New York (Waring, *Excerpts* “October 16<sup>th</sup> 1833”). Four months later, the Medical Society opened a regular meeting with an angry voice to criticize a “vile attempt to stab the reputation and character” of the northern professors, Drs. Rhineland, Davis, and Bedford by circulating a “false and unfounded statement” that these doctors had applied for honorary membership to the society (Waring, *Excerpts* “February 5<sup>th</sup> 1834”). Further frustration stemmed from the fact that Dr. Rhineland, the anatomy professor, did not arrive in Charleston by the opening of the session. Above all, they showed severe hostility toward non-southern professors, stating “popular excitement

had been awakened against our Institution [Medical College of South Carolina], because some of its Professors were not Natives—a feeling which we believe among the intelligent and high minded, has subsided.” The unpopularity of the nonnative professors’ appointment to the college caused a dramatic decline in enrollment in that year: the anticipated enrollment was 12, where the Medical College of the State of South Carolina had 38 (Waring, *Excerpts* “March 1<sup>st</sup> 1834”).

South Carolina’s shift to sectionalism is usually discussed in terms of opposition to the protective tariff, the formation of a state’s right defense, and the actual confrontation with the federal government during the Nullification Crisis. The Medical College of South Carolina revealed strong sectional attitudes that were consistent with those that prevailed in political and economic life. Moreover, as early as 1820, a correspondent writing to a Columbia newspaper argued for filling the vacancies in the professors at the Medical College of South Carolina by South Carolina natives. If the practice of selecting teachers from other parts of the nation continued, he wrote, “we shall incur the risk of having sentiments inculcated into the minds of our youth extremely dangerous to the intersects and prosperity of the southern states” (*Southern Patriot*). Education in the North, or conducted by northerners, would threaten southern values and institutions, an apprehension that led to the promotion of indigenous higher education (Severens 53).

In 1834, nine physicians’ requests for membership were refused by the Medical Society, based on the determination that these physicians had applied for membership for the purpose of overturning the Medical College of South Carolina (Waring, *Excerpts* “December 8<sup>th</sup>”).

1834”). The rejection of admission to the society brought about the organization of a special committee to investigate whether the applicants were “unimpeachable.” In response to the minority protesters against the decision, Dr. Strobel—in addition to the majority of the society—replied that he had voted against the nine physicians “purely” based on “self-defense” because he had been informed that it was the intention of the professors of “the Broad Street College” [Medical College of the State of South Carolina] to introduce these applicants “for the purpose of establishing them to put down the College connected with the Society” (Waring, *Excerpts* “February 2<sup>nd</sup> 1835”).

The division between the two schools also involved political issues. The faculty members of Medical College of the State of South Carolina (see fig. 3, no. 6). were the leading members of the “State’s Rights” party and natives of Charleston or the state. The faculty of the Medical College of South Carolina comprised many “entire strangers,” persons who “were not known beyond the precincts of Charleston and who had, indeed, never before delivered Lectures” (Waring, *Excerpts* “March 2<sup>nd</sup> 1835”). At last, at the December 1838 and January 1839 meetings, the Medical Society accepted a letter of resignation from all the faculty members of the Medical College of South Carolina and determined to transfer all endowments of the Medical College of South Carolina to the Medical College of the State of South Carolina, while reserving for the exclusive use of the Society’s North East Room in the upper story, together with free access to and egress from it at all reasonable hours (Waring, *Excerpts* “December 10<sup>th</sup> 1838,” and “January 7<sup>th</sup> 1839”). The long

controversies and struggles between the Medical College of South Carolina and the Medical College of the State of South Carolina ended with the victory of the native Charlestonians. To Charlestonians, southern medicine was thus like any other religion to protect every part of their social and cultural lives. Their concerns for distinctive southern medical care were as such related to their own medical institutions, operated by the southern physicians and authority. In this sense, the erection of Roper Hospital in 1856 was a new social, political, and medical response to Charleston's longtime need for institutionalized care for the sick poor. Like other nineteenth-century hospitals, Roper Hospital was built and maintained in order to effectively utilize public and private charities in handling the marginalized social groups. It was thus able to become a *heterotopia* or a counterstrategy to the spread of the exposure to the conditions of "bare life." Consequently, the exceptionality of a single real space—Charleston's public building block—where several sites and social groups were in themselves incompatible, but helping to maintain city's stability.<sup>5)</sup>

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5) Right across the public building block, there was the Catholic Orphan House (see fig. 3 no. 7), which was founded in about 1840, overseen by the Roman Catholic Diocese of Charleston, and run by the Sisters of Charity of Our Lady of Mercy of Charleston and the Ladies' Benevolent Society of Charleston. It was the first Catholic orphanage for girls (Catholic Orphanage or St. Vincent's Female Orphan Asylum) in the United States. In addition, the Charleston's Orphan House on Calhoun Street was founded as the nation's first municipal orphanage in 1790. It contained 130 dormitory rooms, dining rooms, play and study rooms, and a hospital ward. Between 1790 and the 1850s, the house lodged nearly 2,000 children who had been abandoned or abused by their families. Each institution had its own hospital wards to treat their inmates, even though some patients were transferred or treated at Roper Hospital after Roper Hospital was founded (Fraser 237; Bellows chapter 5; Murray).

### **Heterotopia of Heterotopias**

Roper Hospital (see fig. 3 no. 8) was the last to be built on this public block, at the corner of Queen and Mazyck (Logan) streets. Interestingly, the hospital was initiated and operated exclusively by the medical profession with the aid of some public funding, but it functioned as a public institution. Therefore, in order to build the hospital, the trustees continuously negotiated with and persuaded the city and state governments and the middle-class fellows.

Before Roper Hospital, there were neither private nor public institutionalized clinical or surgical facilities for Charlestonians except the Marine Hospital. Since the colonial period, the upper and middle-class Charlestonians had actively engaged in philanthropic efforts by institutionalizing the poor sick; in the post-revolutionary period, Charleston was one of the new republic's wealthy cities, and it was physicians who led Charleston's intellectual circle. Since the 1830s, from the experience with yellow fever in 1838 and the operation of the Poor House, the City Council had recognized that establishing the relief hospital fulfilled three important achievements. The first fruit of the charity-based relief hospital was to save private and individual funds for relieving the poor. In an 1838 report on the relief for the sick poor, Mayor Pinckney claimed the necessity of a "public place" in addition to the Poor House Hospital. As Pinckney argued, the public place, which could collectively manage the private "bounties" from individual philanthropists would provide the patients with better care from "careful nurses, regular medical attendance and all the other comforts and accommodations" (Pinckney 4-5). Considering the public need for a hospital, after establishing the

Board of Trustees of the Roper Fund to build Roper Hospital in 1849, the Charleston physicians expected the hospital to open in early 1852 with Thomas Roper's bequest and with sufficient public and private donations from the City Council, the state legislature, and private benefactors (Waring, *Roper Hospital*).

In August 1845 when the Medical Society organized the Board of Trustees for the Roper Fund, the trustees agreed that it would be impractical to attempt to build a hospital until time had allowed the estate to increase in value. Along with the Roper bequest—Roper left to the Society four landed estates on East Bay and Queen Street that amounted to \$30,000—the Roper Fund trustees sought financial aid from three sources, the City Council, the state legislature, and individual charities; among these, they relied primarily on the assistance from the City Council (Waring, *A History of Medicine in South Carolina* 19-20; *Roper Hospital* 4).

As early as July 1849, the trustees and the Medical Society proposed their master plan to the Commissioners of the Poor House and the City Council to erect a community hospital with the funds provided by the Roper bequest and the city. The trustees proposed the necessity of a new hospital that would provide regular visitation from physicians, food of “the proper quality...properly prepared and regularly served,” clothing “sufficient for protecting the invalid against the vicissitudes of the season,” “wholesome, warm and ventilated” lodging, a weather-free space for exercise, “intelligent willing and able” attendants, facilities for bath and douche, the “systematic regulation of protracted convalescence,” and pathology-based patient care. This hospital, they suggested, would have a

separate, “well ordered” hospital building that would be independent from the Poor House; the trustees believed that if the new hospital worked as an auxiliary of the Poor House, it would preclude the admission of possible non-charity patients from the hospital, who were unwilling to mingle with poor sick “strangers.” The trustees expressed their willingness to adopt the role of the Poor House Hospital by treating the transferred patients from the present Poor House Hospital to the new hospital and returning the recovered patients to the Poor House without giving them free discharge. With this proposal, the trustees asked the City Council for \$ 2,000–15,000 in aid, the appropriation of the coffin fund for the Poor House, and the land at the south corner of the Poor House. They also emphasized the importance of the clinical lectures for the students of the Medical College of the State of South Carolina. Referring to the city’s interest in “that noble offspring of nation, talent and bearing,” they claimed, “it will not fail to see how important an aid it will be collaterally affording this institution by assisting in building up Roper Hospital, and in time something handsome will be realized to the hospital from the college by the sale of tickets to the clinical lectures” (*Roper Hospital Board of Trustee Minutes* July 2<sup>nd</sup> 1849).<sup>6</sup> As the trustees considered, the establishment of Roper Hospital seemed to play a variety of roles as a public hospital.

In addition to soliciting money from the City Council, in September 1849 and January 1850, the trustees and the Medical Society petitioned the state for funding for the hospital; they asked

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6) Similar accounts repeated in the petition to Governor Seabrook on 4 September 1849.

for funds from the state equal to the amount the legislature might give and received a favorable response from Governor Whitemarsh Benjamin Seabrook (1793-1855). In their petition, the trustees addressed the four valuable purposes of constructing the new hospital in Charleston. First, with the support and funding of the state, they argued, their proposed hospital would not bound its admission to its city residents but could expand its service to the sick of the remotest districts of the state if they could reach Charleston. They also claimed that the limited amount of the present funds from the Roper legacy and the Charleston City Council would force them to restrict patients from foreign countries, other states, and remote districts of the state and that this rejection of the sick might be against Colonel Roper's philanthropic vision of admission to the hospital of all who might come, without respect to place of residence. Another purpose derived from the sense of "common justice" in dealing with increasing numbers of emigrants from the North. The trustees recognized the situation of foreign paupers who flooded into Charleston "for the most parts, merely in transition, on their way to more promising fields of labor, and disembarking from their long voyage with famine and pestilence consuming their strength." In appealing to the state congressmen with their "localist" interests, the petitioners requested the state's assistance on behalf of Charleston taxpayers, who alone took care of these "useless yet burthensome class" on behalf of other areas of the state. "They [foreign emigrants] do no more than pass through Charleston on their way to more hopeful places," as the petitioners remarked, "but in their transit, they leave here, as they do wherein they go, the traces of

their passage in large contributions to the number of inmates of hospitals, Almshouses and all other charities.” The third purpose of the state funding for the hospital was rooted in concerns for better medical care for the poor. The trustees distinguished Roper Hospital from other alms houses in terms of healing the sick, as arguing that in spite of the annually appropriated, statewide benefits for persons with “famine, fatigue, and confinement,” extended, and urgent relief was definitely wanted for the people who were under the “still heavier infliction of sickness” in addition to being “homeless, houseless, dying.” The last purpose of the hospital aimed at improving medical education in South Carolina by providing clinical lectures and chances for practice: “Unless he [medical students] can acquaint himself with it at the bedside of the hospital patient under the instruction of the experienced physician, he must learn after he goes into practice at the expense of his patients and often at the risk of their lives.” Thus, their appeal for funding for Roper Hospital, according to the petitioners, was made in the “name of science as well as humanity” (*Roper Hospital Board of Trustee Minutes* September 4<sup>th</sup> 1849 and January 10<sup>th</sup> 1850). By bringing up the equal opportunity for ailing individuals to be relieved from diseases regardless of their “nationality, religion, or complexion,” the trustees and the Medical Society were stressing their dual concerns regarding relieving the diseased of the whole state on the bases of the upper-class philanthropists as well as the professional concerns of orthodox practitioners.

Locating Roper Hospital in the public building complex resulted from a series of negotiations between the medical profession and the

city government; initially, the hospital was not planned to be on the same block. As early as January 2, 1850, plans by Mr. E. B. Jones for a hospital were accepted at \$500, but the Roper Hospital Board of Trustees found that the lot was too small (*Roper Hospital Board of Trustee Minutes* January 2<sup>nd</sup> 1850). One week later, the building plan that the trustees submitted was approved by the Medical Society and the City Council. (*Roper Hospital Board of Trustee Minutes* January 10<sup>th</sup> 1850 and May 20<sup>th</sup> 1851). During 1852, The Committee of the Board of Trustees of the Roper Hospital negotiated with the City Council in attempting to enlarge the hospital lot. The committee members met the commissioners of the Poor House for the purpose of conferring on the feasibility of removing the present Poor House from its location and procuring a portion of that lot to be added to that owned by the hospital committee (*Roper Hospital Board of Trustee Minutes* January 30<sup>th</sup> 1852). In February, the hospital committee sent a resolution to the Poor House commissioners that the old Poor House location was unsuitable, specifically, “too circumscribed and limited for the benefit and actual usefulness of the institution” (*Roper Hospital Board of Trustee Minutes* February 16<sup>th</sup> 1852 and February 21<sup>st</sup> 1852). In 1854, the trustees requested a portion of the old Poor House garden in order to enlarge the hospital lot, which spanned 25 feet on Mazyck (Logan) Street (*Roper Hospital Board of Trustee Minutes* April 20<sup>th</sup> 1854). By planning to build a building that would accommodate 120 patients, the trustees solicited the City Council for the present Poor House garden lot, which amounted to 25 feet on Mazyck (Logan) Street, to enlarge the new hospital (*Roper Hospital Board of Trustee Minutes* April 10<sup>th</sup>

1854). The chair of the hospital trustees also contacted the commissioners of the Marine Hospital on the small portion of land that was adjacent to the building to the north of the medical college (*Roper Hospital Board of Trustee Minutes* April 25<sup>th</sup> 1856).

The Roper Hospital trustees of also negotiated with the Medical College to rent or use space. As early as 1849, the trustees asked the faculty to confer part of the school's land on Queen Street "for the better accommodation of the hospital building," which worked in favor of the trustees (*Roper Hospital Board of Trustee Minutes* November 20<sup>th</sup> 1849). The Medical College transferred the designated land to the hospital on the condition that the college's concession of the land would secure for the medical students the "right to attend the clinical lectures" at the hospital at a ticket price that would not "exceed the average sum paid for all such means of admission at the different institutions of a similar character in the United States" (*Roper Hospital Board of Trustee Minutes* April 3<sup>rd</sup> 1850). Responding to this give-and-take proposed by the college, the trustees resolved to provide an exclusive, separate room for the surgical and clinical patients by treated by the faculty physicians—which would later be renamed the "Faculty Ward" or "College Ward." The trustees claimed that the patients, who would be admitted at the request of the college's faculty, should be admitted by the trustees themselves and governed by the same regulations as those of the hospital (*Roper Hospital Board of Trustee Minutes* June 10<sup>th</sup> 1850). This resolution referred to the trustees' earlier motion, which disagreed with the arrangement with the college to accommodate the surgical patients at that time in their private hospital on the same footing as the

Charleston hospital's patients, including "the privilege of attendance by other physicians" than the hospital's house physician (*Roper Hospital Board of Trustee Minutes* February 14<sup>th</sup> 1850). In 1852, the Medical College made an official application to the trustees for the use of the third story of the newly constructed hospital. Although it was primarily founded based on benevolence for the "foreign paupers," the hospital itself was also a social locus of the medical profession.

In caring for the poor sick, Roper Hospital was an expression of the southern paternalism of wealthy planters and merchants. It was a symbolic monument for the Charleston physicians in fulfilling their clinical and teaching purposes. In Charleston's public building block, the symbolic setting of the "promising" medical profession, hospital doctors and medical students experienced dilemmas related to the creation of their self-identities as physicians. On the one hand, they simply detached themselves from the "unfortunate, sick people" in their workplace—the hospital wards—in their pursuit of "noble professionalism." Even though Roper Hospital was the last addition to Charleston's public building block, the story of its establishment touched on many social, political, and medical issues surrounding health of the city: Roper Hospital was thus a heterotopia of the heterotopias in the public building complex.

In sum, the public building complex as a whole was an attempt to establish a segregated "heterotopic place" for the middle-class ruling class, laboring class, "paupers," and the medical profession. As this specific block was designated to serve certain purposes, the Charleston's urban space was built through a process of conceiving,

planning, and negotiating a variety of political, social, cultural, and medical ideals and worries, rather than a series of fixed physical entities. In this sense, the concept of heterotopia in Charleston should be understood as a shared experience of “otherness” and (or) “enacted utopia,” rather than as a stigmatizing exclusion.

#### **4. Conclusion**

In its overall structure, my study reflects historical particularities by mapping a specifically designed place in a certain time of period, specifically, a public building block in antebellum Charleston. The study articulated the relationships between historic conceptions of the public and the production of the built environment and attempted to prove that much of the urban planning and construction of buildings sprang from the interweaving of local and national architectural patterns, the interaction of traditional practices with professional precepts of urban design, and the sociocultural ideas regarding the urban poor. Therefore, it revealed one of the various ways in which urban institutions were purposefully designed, and located according to individual cities’ own regional, monumental, symbolic, and public aspects. As architectural studies scholar Camila Wells states, “most buildings can be understood in terms of power or authority—as efforts to assume, extend, resist, or accommodate it” (Wells 9-10). As such, the study of the built environment is partly about the issue of power and authority. As noticed, however, this issue was not bound to the political arena but reached to medical care and education, and

ultimately to the whole society.

In Charleston, the public building complex located on the right corner of the Charleston Peninsula was a “peculiarly designed” space to serve the city in terms of medical care as well as to manage the socially marginalized. The block’s sharp separation from the other part of the city brought about a fractured landscape: one “orderly, prosperous, genteel and bathed in sunlight” and the “other looming, vulgar and steeped in darkness.” Interestingly, even though the public building block was separated from the fancy parts of the city, the architectural styles of the buildings were never separated from the national and local trends. Rather, this block was still forming an integral part of the city’s monumental urban plan: the Greek Revival architectural style was pervasive in public building structures throughout the antebellum period.<sup>7)</sup> The positive or desirable elements and places in urban medical services were offered by the city’s socially and culturally “ideal” sorts—the middle-class medical men—in

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7) Greek Revivalism was based on order, which was categorized mainly by the type of column used. Each order consisted of the column, its base, plinth, or pedestal (if any), capital (the crowning feature of the shaft), and entablature (the decorative horizontal member that surmounts the column, divided into three bands—architrave, frieze, and cornice). In the Greek style, there are three orders, which are progressively slimmer and more richly decorated: Doric, Ionic, and Corinthian, named after the regions of Greece where they are said to have been first used. The American townhouse was the most common building type constructed in this style (Vogt 113). McNinnis, however, argued that the popularity of the Greek Revival style in public buildings was not applicable to architecture of charity and philanthropy such as Roper Hospital. These buildings were separately classified using the Italianate architectural style in the 1840s as an alternative to the Gothic and Greek Revival styles, although the medical school buildings and many municipal buildings in Charleston followed Greek Revivalism (McNinnis 105).

a symbolic architectural monument to civilized society. The negative spaces were “deficient, unsuitable” ones used by undesirable types such as vagrants and the homeless, unruly slaves, young unskilled laborers, jailers, and the patients coming from the marginalized social class. Such elements and people represented societal deviance or abnormality. The socially, politically, and culturally conceived spaces in the city produced a fundamental fact of massive contradictory effects in the streets, and these contrasts were inscribed in the built environment itself, making the Charleston street grids a mosaic of sociopolitical and cultural differences and group frictions. The drama of “sunshine and shadow” in the nineteenth-century streets brought about a melancholic cityscape by intentionally locating the space for the socially-marginalized in the “right” place—the place where heterogeneous humans, ideals, and stories were contested and interwoven in such a way as to control the body and mind.

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**Abstract**

**Heterotopic Landscape in Antebellum Charleston,  
South Carolina**

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This study explores the public building block of antebellum Charleston in the spatial context. By collaborating with the recent spatial studies and historical documents to unveil the issues surrounding the power of place, and the natural and urban landscape, this study reveals that Charleston's public building complex was a distinctive example of Michel Foucault's notion of *heterotopias*. Through the lens of heterotopia, the story of Charleston's public building block—Poor House, Work House, Jail, Medical College of South Carolina, and Roper Hospital—reveals the ways that the colorful social and cultural fabric was woven by both “desirable” and “undesirable” layers of threads. By embracing incompatibilities, the public building block in a designated site emulated “a realized utopia” in the context of “healthy city.”

**Key Words**

heterotopia, Charleston (SC), antebellum period, medicine, landscape