Sir James McGrigor – An Appreciation
by
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It is a particular pleasure to have been invited to give this McGrigor Lecture and in doing so to honour with you the memory of a great man who holds a very special place in your history and in that of my Corps. He had a deeply personal regard for your society which he helped found. In his autobiography, published in 1861, he wrote of your society thus: “From the earliest period of the institution of the medical society of Aberdeen, in whatever corner of the globe I was stationed, I never ceased to entertain the warmest interest in its prosperity. I watched its advancement and its success with the anxiety of a parent. By my own subscriptions, donations of books, and continued warm importunities to my numerous friends, I obtained no small proportion of the funds required for the erection of the handsome building which the society now possesses, and which contains its valuable library, museum, etc.” He is, of course, referring here to the fine building in King’s Street which was your home prior to moving to your new building in 1973.

Why did McGrigor choose medicine and why also the Army? He was born in 1771, the oldest of three sons, of Colquhoun McGrigor, a merchant of Aberdeen. He showed early signs of his future distinction by winning the first prize in the high class at the end of his five years at Aberdeen Grammar School after which he proceeded to Marischal College and in due course took the degree of AM. During his time at the College he began his interest in medicine through a number of friends and associates who were medical students at the Infirmary. He also admits to having his fancy taken by one of the senior students, a Mr Farquhar who was appointed assistant surgeon to a Regiment based in Jamaica and appeared at the Infirmary in full regimentals including a cockaded cocked hat. He met other young men in the military at that time and clearly his two-fold interest was founded from then.

He studied under a Dr French at the County Infirmary, attended classes there for three years, and afterwards attended classes in Edinburgh and in Glasgow. After completing his education, at length he departed by ship for London in 1793 where his earlier interests in the Army were rekindled. He recalls that “The War of the Revolution against France had commenced and I met many friends from Aberdeen, and stimulated by everything around me, I determined on serving as a Medical Officer in the Army”.

As a backdrop to examining his achievements it is important to remember the conditions of the age in which he entered the Service. Medical education was of course totally unregulated and the knowledge and capability of those professing to be surgeons or physicians varied enormously. (A census in 1841 suggested that about 5,000 of the 15,000 people then practicing medicine were unqualified!) Anaesthesia and the microbial theory of disease would not appear until decades after his long life. Infectious disease was endemic and epidemic with huge mortality rates and nowhere more than in the Army, both in barracks and in the field.

George III was on the throne of England, we had but recently lost the American Colonies, and the French Revolution had stirred up widespread republican feelings. McGrigor himself recalls that “when the Revolution broke out it was hailed with joy by no small number of the students in Edinburgh”. He brought back with him the contagion of republicanism to Aberdeen where it was warmly advocated particularly in the University. His advocacy of the Revolution caused uneasiness among some of his friends who cautioned him against giving expression of his opinions. He goes on to admit that his opinions were, in no long time, entirely changed after entering the Army.

And so he entered the Army by purchasing a surgeonship in the newly formed 88th Foot, the Connaught Rangers, in 1793 and there began a military medical career which was to span 58 years. I intend to devote most of this talk to considering McGrigor’s achievements as Wellington’s principal medical officer in the Peninsula, but let us first see the breadth of military medical experience which he gained before being faced with his greatest challenge.

He served with his Regiment in the Channel Islands and then in the Flanders Campaign of 1793-1794, during which time he narrowly survived two attacks of typhus fever and a fire at sea. Thence, in 1795 he sailed with his Regiment as part of Sir Ralph Abercrombie’s expedition to capture the Caribbean islands of St. Lucia and Grenada from the French. During this time he was faced with the ravages of dysentery and yellow fever and remarked the number that died from yellow fever was four times that of those who fell by bullet or bayonet. He writes that he felt a conviction that in many cases the disease was communicated by contagion, although not in its origin a contagious disease. The mortality, particularly of officers, was frightful and he describes vividly, “Of the officers quartered at Richmond Hill (Grenada) many came down each morning to St. George’s to see their friends in other Corps... the first question put to an officer entering the coffee room was, who died since yesterday? And almost always several well-known officers were announced”. However he...
survived and with the remnants of the 88th was ordered back to England.

After a short stay, the Regiment embarked for India on Christmas Day 1798 to serve under Sir Arthur Wellesley’s command in fighting the native state of Mysore. In 1801 he was appointed principal medical officer to the Anglo-Indian Army commanded by Sir David Baird.

The aim of this expedition was to land at Suez and entrap Napoleon’s Army in Egypt, between it, a British Force landed at Aboukir Bay and the Turkish Army advancing from Syria. In the event the force landed further down the Red Sea because of contrary winds, and was faced with a 120 mile march across the desert. McGrigor was faced with scurvy, ophthalmia, and heat exhaustion, but demonstrated that, with well organised and adequate medical care, a British Army could cross the desert and remain a viable fighting force.

He returned to Bombay after this expedition and became the Superintendent of Quarantine, a crucial public health position in that festering Indian sea port. Then back to England in 1804, a short tour as surgeon to the Royal Horse Guards (The Blues) and then promotion to Deputy Inspector of Hospitals, first at York and then in 1806, to South West District at Portsmouth.

Here he had to deal with the sick and wounded evacuated from Sir John Moore’s ill-fated expedition evacuated from Corunna. Debilitated from the fatigue and privations of the long retreat and, wounded and sick huddled together with the healthy in overcrowded transports, epidemic typhus was raging by the time they arrived in England and the number of sick and wounded overwhelmed the accommodation available in Portsmouth. He had a huge problem. Reinforced by military medical officers from the Household Troops and the Militia and local civilian practitioners he used all ordinary hospital accommodation, converted barracks, the large Royal Naval Hospital at Haslar and finally ships as floating hospitals to accommodate the sick as typhus cases continued to accumulate. All his energetic talents and initiatives as a medical administrator were proven in this experience.

Later in the same year he was promoted Inspector General and was involved in yet another military medical catastrophe. He went to the Scheldt estuary to replace the stricken principal medical officer who had been attempting to deal with an epidemic which had struck the British expeditionary force of 40,000 troops despatched to the Low Countries. The Army had been landed on the island of Walcheren and decimated by typhus, dysentery, but most significantly malaria which was endemic in the area. When the expedition was finally evacuated two hundred had died in combat, four thousand from fever, and eleven thousand spent months recuperating from fevers.

Thus McGrigor experienced in these years the horrendous results of armies decimated by little understood disease. There had been until this time no systematised study of Army Hygiene, Military Medicine and Military Surgery. Many military medical men were poorly trained and this was worsened by the need to recruit large numbers to support armies in the field. The medical board was forced to lower its already lenient requirements to entice virtually anyone with the rudiments of medical or pharmaceutical knowledge to accept a commission. At the same time such was their status that medical advice when offered correctly was often ignored by Commanders.

Similar problems faced Arthur Wellesley in the Peninsula. By 1807 Napoleon had become master of all Western Europe – save Portugal, which refused to join the continental system. French armies occupied Spain and Portugal and in 1808 deposed the King of Spain. The first British army under Sir John Moore landed in support of the Portuguese in that year and was almost trapped before being evacuated from Corunna as we heard earlier.

In 1809 the British returned to Portugal under Wellesley, landed at Lisbon and attacked the French under Marshal Soult at Oporto. Wellesley’s policy thereafter was to clear the French from Portugal, hold it as a base for operations and advance from there into Spain when he was strong enough. There were five gaps in the mountain frontier between Spain and Portugal from which led the main river valleys. These gaps were the key to the defence of Portugal. He made in-roads into Spain along the Valley of the Tagus and in July won the Battle of Talavera, after which he was elevated to the Peerage as Viscount Wellington. But renewed threats from Soult caused him to fall back towards Mondego Bay.

By the winter of 1809-10 it looked as if the French could concentrate sufficiently massive forces to finish off Wellington in Portugal. He therefore retired before Marshal Massena’s army abandoning the frontier fortresses at Ciudad Rodrigo and Almeida. He defeated Massena at Busaco on the Mondego River but continued to fall back to the immensely strong line of Torres Vedras which had been previously prepared under his instructions.

In the winter of 1810-11 the French and British faced each other, the British secure and well supplied in the lines, the French far from their bases in a hostile country; and so by March of 1811 Massena had to retreat and Wellington began the long slow advance which would last over the next three years.

Thoughout all this time the medical problem was considerable. Except after set piece battles the number of sick far out-numbered the number of wounded, and the percentage of the Army incapacitated was huge; this in itself limited Wellington’s capability by decimating his fighting strength. In a letter to Lord Liverpool in December 1809 Wellington claimed that over 10 per cent of his men were constantly on the sick list and lamented that “You can have no ideas of the difficulties
to which I am reduced in moving the Army from its present quarters, for want of medical assistance, and if unfortunately the troops should be sickly on their march, I do not know what is to become of them". In 1811 he writes, "It is obvious, however that if this system continues much longer, the whole Army will be sick or must disband". What was the problem?

It has been suggested that Wellington suffered from a chronic shortage of surgeons, a defective hospital system, and inaccurate regimental returns on the numbers of sick and wounded – factors which tended to limit the mobility and efficiency of the Army. Certainly the surgeons were for the large part inexperienced, probably not deployed as effectively as they might have been, and not under sufficiently coherent medical control; but the hospital system was compromised from the outset by logistic considerations, or, rather, lack of logistic arrangements.

The accepted policy of treating sick and wounded in the regimental hospitals had to be abandoned when Wellington ordered that bullock-carts carrying their equipment should be withdrawn because they interfered with movement of the Army. This meant that there were no beds in which to treat sick men nearer than the General Hospital and all cases had to be sent to the rear. Only a single cart was retained to carry the sick, and this cart, drawn by oxen and plodding along at two miles per hour with screeching solid wheels, was anything but comfortable for the sick and torture for the wounded.

Sick not carried in this manner were aggregated under the care of a staff surgeon until similar carts were found from the commissariat. Assistant surgeons from each regiment were left behind with them until they were properly handed over, thus reducing the direct medical support available to the fighting battalions.

There were no intermediate medical stations between the regiments and the General Hospitals, no mobile field medical units and no dedicated medical evacuation transport. This situation undoubtedly caused increased mortality, slowed down recovery and thus delayed return to duty and was wasteful in medical resources. By comparison Baron Larrey had introduced the concept of a flying ambulance or ambulance volante into the French Army some years previously. This unit had an establishment of 113 officers and men including 14 surgeons, all mounted and under the command of a Surgeon Major of the First Class. It moved with the Division and rapidly transported wounded to the rear.

And so the medical problem appears to have been a combination of inexperienced and poorly controlled medical staff and lack of logistic resources. As well as the enemy and the climate, the Army was threatened by epidemic and endemic disease. The principle cause of manpower wastage was fever and it was classified at that time into four categories: simple or continued fever, intermittent, remittent, malignant or typhus. Of these fevers two were distinct types – intermittent was malaria, malignant was typhus. Continued and remittent fevers embraced a multiplicity of disease which were at that time indistinguishable including typhoid, the paratyphoids, fever associated with dysentery, relapsing fevers both tick and louse-borne and multiple malarial infections. The malarial season was mainly June to September while typhus was prevalent in the winter. Dysentery of course was also more common in summer.

Principles of management can perhaps be better understood by the current opinion of the time that disease was caused by intemperance, exposure, marsh vapour and contagion. Exposure to heat or cold might cause inflammation of the lungs or bowel disease. If exposure was severe and wet, cholera, rheumatism or consumption might result (flannel shirts were considered the remedy). Marsh vapour induced fever and dysentery. Contagion occurred only from uncleanness and lack of ventilation, and it was considered that typhus could occur spontaneously for want of cleanliness, poor food, depression of mind and stagnation of air.

And so when Wellington broke out from the lines of Torres Vedras in early 1811 the medical problems of his troops began again. From April 1811 the sick rate steadily mounted. From thirteen per cent to twenty per cent in May, twenty-four to twenty-six per cent in June and September. Between April and June, numbers in hospitals doubled from 6,160 to 12,392!

Despite this the Battles of Fuentes de Onoro and Albuera were fought and won in May and the British Army was once again across the Spanish border.

By October the Army was in winter quarters dispersed over Central and Northern Portugal; the sick rate was thirty-two per cent and over 17,000 men were in hospital. Wellington was alarmed and considered that the Army was quite unable to take on any task of magnitude. He wrote home to the Horseguards requesting the Duke of York to send him an Inspector of Hospitals in whose talents and judgements he could place entire confidence. To quote his own words, "I should have the most active and intelligent person that can be found to fill this station". The Duke had no hesitation in sending him McGrigor.

By the turn of the year the British Army was engaged in the investment of Ciudad Rodrigo in the north and Badajoz in the south which were captured in January and March 1812. Throughout the year most of the manoeuvring was to be in Spain culminating in the great Battle of Salamanca in July. The British Army was therefore constantly lengthening its lines of communications from its bases in Portugal.

McGrigor landed in Lisbon in January 1812 and lost no time in inspecting the whole medical service. He wrote that on arrival, "I found an inundation of complaints of the inadequacies of the means which the medical department had for operating the campaign".

After inspecting the hospitals in Lisbon he made three propositions to Wellington. These were:
“As to the large proportion of the Army in hospitals particularly at Lisbon I propose that in future only special cases of either wounds or sickness should be sent to the rear, and such only should be approved by me. In order to effect this, I submitted that each Corps should have a temporary hospital of its own, where all slight cases of disease and wound should be treated by the Regimental Medical Officers, under the superintendence of the Principal Medical Officer of the Division.

2) That all sick and wounded officers of the same description instead of being sent to Lisbon as heretofore should have a temporary hospital of its own, where all slight cases of disease and wound should in the first instance be treated by the Regimental Medical Officers, or to be under the care of the medical officers of their Regiments.

Finally I gave a statement of the sick I found at Lisbon, proposing that one part of them, officers and men should be sent as inefficient to England, and the remainder ordered to join their Regiments in the field for duty, or to be under the care of the medical officers of their Regiments”.

A third proposal was for the treatment of every case when possible to be carried out within his Corps, and continued at that level for as long as it could be done. “In acute disease everything depends on active treatment being pursued at the very commencement”. He also developed other sound principles rapidly after his arrival.

Among many deficiencies he found in medical care of the sick and wounded, he noted two especially outstanding. One was that all kinds of cases, wounds and all manner of infectious diseases were herded together in wards, accounting for the high hospital mortality. Another was that there were no convalescent hospitals. On this he writes as follows, “I established at Coimbra a regulation which I subsequently found of the greatest service in all our hospitals: separate hospitals for care of continued fever, for dysentery, for wounds and ulcer and for convalescence”. This segregation of cases was obviously being carried out for the first time and was very much a first for McGrigor. He also established the principle of convalescent depots and the management of the sick and hurt by a system of grading that obtains to this day. Many of us would think, or like to believe, that the system of convalescent depots was a modern development in the care of the sick and wounded in the Army, but once again McGrigor was the pioneer in this. He writes, “At Coimbra I found that relapse from disease was extremely frequent, indeed the hospitals were principally fed by relapse cases from the depot. Men sent from hospitals as recovered, generally returned from the depot in a few days and with severe disease, and it was observed that a large part of the mortality was from relapses. The recovered men went from the warmer comfortable hospitals to the depot which was a dreadfully cold place where they had only one blanket, and where the duty they had to perform was rather severe. I therefore established a convalescent hospital in a convent, and to this place every convalescent was sent from all the hospitals and remained for two or three weeks”.

McGrigor continued to introduce more reforms in the medical service; he improved the diets, the ventilation and the hygienic environments in the hospital; he established hospital boards to review the condition of patients; he promulgated a sanitary code for the Regiments in the field; he began to introduce sprung wagons for the transportation of the wounded and he continually sought to dignify the medical department itself by rewarding and promoting meritorious surgeons.

McGrigor was very conscious of the need to improve the morale of his medical officers and right from the start he made a point of requesting Wellington’s assistance in this. When he first reported to Wellington at the siege of Badajoz he requested that Wellington should insert a word of praise into his report concerning the services of Army doctors during the Badajoz Campaign. Wellington hesitated at first, for there was no precedent in the
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British Army for siting lowly surgeons in bulletins from the battlefield. "I have finished my despatches", replied Wellington, "but, very well, I will add something about the doctors". The Duke's commendation of the surgeons of Badajoz appeared in the London Gazette, the first time that a field commander publicly praised military doctors for their valour and skill. Wellington's example which he repeated after the battle of Salamanca established a tradition in the Army: henceforth after every major action commanding officers would cite the bravery of their medical officers in battle.

And so McGrigor gradually developed a well controlled and effective medical service. Wellington respected his judgement and supported him. He was particularly impressed with the accurate returns of sick and wounded and of his correct estimates of the number of men who would be fit for combat. He never got the transport which he needed, despite the fact that Wellington accepted the need. After Salamanca in July 1812 in fact he incurred Wellington's fury by ordering up commissariat transport to clear the wounded without prior authorisation, but he finally achieved agreement to a chain of small mobile regimental hospitals for temporarily incapacitated troops, the forerunners of the Second World War Field Dressing Stations. In the autumn of 1812 he had problems with housing up to 4,000 convalescents in winter quarters and he obtained Wellington's support in obtaining from England prefabricated buildings in which to house them.

The interesting point to make is that during this period of 1812-1813 the sick rates did not fall but return to duty improved. Indeed in May 1812 the sick rate was 29.9%, it fell through June to 25% and in July to 24% but rose again sharply in August to 34.7% and 35% in September. In the three months June to September hospital admissions numbered 55,346, a total greater than the whole strength of the Army! Obviously the majority were slight cases treated locally and returned to duty quickly because the Army was marching and fighting throughout this period.

On the tables of admissions it is of interest to note that admissions to general hospitals were halved between 1812 and 1813 (Table 1) although mortality rates were not so greatly reduced and were in fact a higher percentage of those admitted. Also note the huge admission rates of patients with continued and intermittent fever into regimental hospitals, but the relatively small death rate from intermittent compared with continued fever (Table 2 & 3).

Through 1812 and early 1813 McGrigor continued to augment the regimental hospitals, reducing the flowback into general hospitals and with it the morbidity and mortality of evacuation, and the incidence of typhus and other infectious diseases in the rear hospitals. As a result there were more men with the colours than ever before and it is estimated that the change in medical policy added the equivalent of a division of fighting troops to the Army by the time the battle of Vittoria was fought in June 1813. By the time Wellington reached southern France he remarked "during the five years that I have commanded the Army I have never known it so healthy".

At the conclusion of the war against Napoleon, Wellington wrote, "I have every reason to be satisfied with the manner in which Mr McGrigor has conducted

Table 1

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<thead>
<tr>
<th>British Army in the Peninsula</th>
<th>General Hospital Admissions and Deaths</th>
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<tbody>
<tr>
<td>Admitted</td>
<td>Died</td>
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<tr>
<td>1812</td>
<td>95,075</td>
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<tr>
<td>1813</td>
<td>46,715</td>
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<tr>
<td>Dec 1813-</td>
<td></td>
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<tr>
<td>June 1814</td>
<td>22,013</td>
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<tr>
<td>Regimental Hospitals</td>
<td></td>
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<tr>
<td>1812-</td>
<td></td>
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<tr>
<td>June 1814</td>
<td>176,067</td>
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Table 2

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<th>British Army in the Peninsula Regimental Hospitals</th>
<th>December 1812–June 1814</th>
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<tbody>
<tr>
<td>Principal Causes of Admission</td>
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<tr>
<td>Continuous Fever</td>
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<td>Intermittent Fever</td>
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<tr>
<td>Dysentery</td>
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<td>Rheumatism</td>
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<tr>
<td>Pneumonia</td>
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<td>Remittent Fever</td>
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<td>Typhus</td>
<td>1,795</td>
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Table 3

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<th>British Army in the Peninsula Regimental Hospitals</th>
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<td>Principle Causes of Death</td>
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<tr>
<td>Continuous Fever</td>
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<tr>
<td>Wounds</td>
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<td>Pneumonia</td>
</tr>
<tr>
<td>Various</td>
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<tr>
<td>Enteritis</td>
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<tr>
<td>Hepatitis</td>
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the department. I consider him one of the most industrious, able, and successful public servants that I have met with”.

Why had McGrigor been so successful? First, he had clearly in his mind the prime task of an Army Medical Service which is to conserve the fighting strength by preventing disease wherever possible and returning wounded and sick soldiers fit to duty in the shortest possible time. To do this he saw the need to provide a continuum of medical care from wounding to convalescence within the whole theatre of operations. The siting of medical facilities, the deployment of surgeons and the provision of evacuation transport within this system would vary constantly with the incidence of sick and the tactical situation. To anticipate correctly he therefore needed accurate medical returns from his doctors and early knowledge of his Commanders’ intentions. When feasible he treated and held the sick and wounded forward. He reduced evacuation to a minimum, but pressed for acceptable evacuation transport when he needed to evacuate his casualties. He introduced intermediate medical stations on the line of evacuation.

He introduced a theatre holding policy evacuating to England those unfit to continue campaigning. He saw the need for a system of convalescent units to make fit for the field those who no longer required general hospital treatment. In addition and without the benefit of a scientific basis for his views he insisted on sound preventive medicine principles both in his instructions to medical officers in regiments, his siting of medical installations, and his segregation of the wounded and infectious cases. In all this he developed the concepts of medical care on the field of battle which hold true today.

He achieved his objectives through his own energy and personality. He maintained personal control of the whole medical system through a constant knowledge of the extent and deployment of his own medical resources and an up-to-date appreciation of the medical requirement. He moved continually around the area of operations to assess the need at first hand, but based himself at the Headquarters of the Army where his personal relationship with his Commander was all important. His development of such a position of trust cannot have been easy to achieve when one considers the formidable personality of Wellington and the vast personal relationship with his Commander was all preoccupied him to the exclusion of the medical dimension. Wellington however was one of the great captains of history who understood how essential to his stature, put his trust in him and supported him.

In recognition of the part he played in the Peninsular War he was knighted in 1815 and in that year became Director General of the Army Medical Department. The Medical Board of Physician General, Surgeon General and Inspector General of Regimental Hospitals had recently, for good reason, been reorganised with the appointment of a Director General and this post McGrigor held with great distinction for 36 years until his retirement in 1851.

During this time he developed policies to set right deficiencies which he had experienced in his long years on active service. He recognised that military medicine, surgery and hygiene were specialist subjects in themselves and arranged for newly joined medical officers to receive instruction in these subjects at Fort Pitt, Chatham, where he also established a medical museum and library. This was the forerunner of his long-term aim which was an Army Medical School. Financial stringency after the Napoleonic Wars prevented such a development and it was only after the catastrophe of the Crimea that his dream was realised. However he insisted on raising the professional standards of entry for doctors into the Army and he demanded of these doctors accurate medical returns, not merely as heretofore to account for the costs of medical treatments and diets which they had prescribed, but to encourage them in accurate clinical observation and to provide data on which the health of the Army could be assessed and measures taken to improve it, particular stress being given to barrack hygiene, food, exercise and clothing, as well as conditions in the field.

He maintained a special concern for the well-being of medical officers and their families and he instituted both the Army Medical Officers Benevolent Society and the Widow’s Friendly Society which continue today as our Corps Charities. In so many ways he was the founder of the Royal Army Medical Corps as we know it today.

He retired full of honours – a Baronetcy in 1837 and KCB in 1850. His military honours included the medal of the Imperial Ottoman Order of the Crescent, conferred by the Sultan of Turkey, and the Portuguese Order of the Ancient and Most Noble Order of The Tower and Sword for his services in the Peninsula. A Knighthood of Guelph, a Hannoverian Order, was conferred on him after Waterloo. His academic distinctions included Fellow of the Royal Society in 1816, and Fellow of the Royal Society of Edinburgh, LLD Edinburgh, FRCP (London and Edinburgh), both Edinburgh and Aberdeen conferred on him the Freedom of their Cities and Aberdeen thrice selected him as Rector of the University. He was Honorary Physician to George IV, William IV and Queen Victoria. It is said that when 75 years of age he asked leave to retire but the Duke of Wellington replied, “No, no, Mac, there is plenty of work in you yet”. Now in his 82nd year he felt it was high time to make way for a younger man. As befitted his long and distinguished career his retirement did not pass unnoticed by the Government, and in the Army estimates for 1851 it was stated: “In the Army Medical Department, the Services lost by the retirement, not, I am happy to say, by the death of Sir James McGrigor, an officer to whom the public is much indebted”.

And the Lords of the Treasury in fixing his pension expressed their high approbation of his, “long, able and most meritorious services”.

Sir James McGrigor – An Appreciation
He made London his home after his retirement and we are told, “the urbanity of his manners, the benevolence of his disposition and the simplicity of his heart drew around him for the remaining years of his eventful life a large circle of friends”. He died on the 2nd April 1858 in his 88th year and was buried in Kensal Green Cemetery.

There are several permanent memorials in his honour. In 1865 a statue was erected in the grounds of the Royal Hospital Chelsea and now stands in the forecourt of the Royal Army Medical College at Millbank. Subscribers to this included the Duke of Cambridge who was then Commander in Chief, 14 generals and many other combatant officers. In your city a stone obelisk in Duthie Park also commemorates his outstanding services. When Wellington College was founded McGrigor was assigned one of the niches reserved for the reception of statues or busts of the principal officers, the contemporary statesmen and the personal friends of the Duke. In our Headquarter Mess hangs his portrait by Sir David Wilkie. One of the highest tributes in which McGrigor would have rejoiced was the statement that “he rendered the most effective service to his country by appointing to the Army gentlemen of high professional attainments”.

It has been a very great pleasure, a privilege and an honour to pay tribute to the memory of an outstanding Army doctor and a great Aberdonian.

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