It is customary, and indeed proper, for those who give commemorative lectures to preface the main subject of the discourse with a few remarks about the man whose name is honoured. I intend to go beyond what is customary in devoting the whole of my lecture to Dr Gee, not with the purpose of giving a straightforward account of his life and works but rather with the object of comparing and contrasting knowledge of children’s diseases and paediatric practice today with that of a century ago, so brilliantly depicted in his published work and reported sayings. Samuel Gee was a literary artist and, even if one had no interest in the subject of his writings, they could still be read with delight for his masterly and expressive use of the English language; and the pleasure of reading his notebooks is enhanced by his clear and elegant handwriting.

An excellent life of Dr Gee was written by Dr Oliver Garrod whose sources included the Recollections of Samuel Gee by Dr Wickham Legge, and Gee and his Friends by Sir Humphry Rolleston. Samuel Gee was born on September 13th, 1839. His father was a London businessman with literary interests who lived to the age of 87; his mother, Lydia Sutton, died at 89. There were three other children of the marriage but they all died in infancy. Mr and Mrs Gee are said to have been ‘Rigid and devoted parents, typical of their age, yet always spoken of by their son with gratitude and affection’. At the age of 13 Samuel Gee went to University College School in Gower Street where he was reasonably successful in his studies but in no way outstanding. One of his school reports stated ‘that he did not do as well as he might and that he could do much better if he chose’. I wonder for how many centuries school masters have been saying precisely the same thing and for how many centuries they will continue to do so. In this instance the school report did not err.

At the age of 18 he became a medical student at University College Hospital and there he had an exceptionally successful career, obtaining a Gold Medal of the University of London in chemistry for the intermediate examination, and honours with a Gold Medal for medicine in the Final M.B. After qualification Gee became House Surgeon at University College Hospital. Dr Garrod quotes the following story about him at that time. ‘He was a quiet looking fellow of whom those who knew him little thought they might well
gain advantage; but on coming to close quarters they were surprised that he could be hard, implacable and unbending. Thus one Sunday night, when it was not his turn to be on duty, he found that the others had left without giving notice; so, seizing his hat and coat he marched into Gower Street, whence only an appeal to his better nature could bring him back. There is nothing new in this world, not even rebellious resident medical staff.

In 1862 he was appointed House Surgeon at the Hospital for Sick Children, Great Ormond Street. In those days posts of House Physician did not exist and hospital residents were either house surgeons or apothecaries. In the following year he was appointed Medical Registrar and Pathologist. The post holding this title, which I was once lucky enough to hold, has only recently been abolished. In 1865 he obtained his MRCP and MD and in the same year was elected Assistant Physician with charge of Out-Patients to the Hospital for Sick Children. Three years later he was appointed Assistant Physician to St Bartholomew’s Hospital; it was even more unusual in those days than it is today for vacant posts in London teaching hospitals to be filled by outsiders.

In 1875 he was elected a full physician at Great Ormond Street, and in 1878 at St Bartholomew’s. He retired from both hospitals at the age of 65 in 1904. Gee married Miss Sarah Cooper when he was 34 years old. They had two daughters, one of whom, together with his wife, predeceased him. He died in his 72nd year while on holiday in the Lake District. A postmortem examination, carried out on his instructions, showed extensive atheromatous change in the aorta and aortic valves.

There are two aspects of the age in which Dr Gee lived about which I would like to comment. Sir Peter Medawar has written a sternly worded, amusing and convincing corrective to the view that science as a whole becomes more and more difficult for a single individual to grasp. It was with this idea in mind that I looked up the examination papers which Dr Gee had to face when he attained his Gold Medal in medicine from University College in 1861. Certainly they present a more exacting test of knowledge than do the London University Final MB papers today. The examination consisted of seven three-hour papers, a *viva voce* interrogation, a medical clinical examination, and what is rather chillingly entitled ‘practical examination in surgery’. The seven papers consisted of the following: one on surgery, one on medicine, one on midwifery, one on forensic medicine, one a translation from Latin to English and vice versa on the English pharmacopoeia, and one—and I would remind you that this was the final examination—on comparative and human physiology. Two of the questions read as follows: ‘Give an account of the structure of the Organ of Voice in Man, explaining the mode of action of its
various parts. State how the vocal organ in Birds differs from that of Man’, and ‘Describe the structure of the testis and the microscopical characters of the semen in man. State what animals have motionless spermatozoa’. Those who wished to sit for honours had to have been placed in the First Division in the Pass examination and had to take an additional written examination on physiology, comparative anatomy and medicine.

The MD examination that he took four years later included two papers on medicine, a case commentary in medicine or midwifery, a clinical examination and a *viva voce*. The medical case was that of a poor girl, whose age was not stated and who died after an illness lasting two months, the symptoms, signs and course of which were very fully described. I must confess that I doubt if I would obtain pass marks, not that my confession is an indication of the severity of the test.

The first paper in this examination was on Logic and Moral Philosophy. My Oxford paediatric colleague, Dr Robert Beazer, who is a graduate in philosophy as well as in medicine, tells me that this is pretty straightforward English philosophy of the School of Locke, with the exception of Question 5, which is a little puzzling: ‘Enumerate and describe the feelings arising in the exercise of the Muscular Organs’. Professor Alexander Bain, the senior examiner, had been a protegé of John Stewart Mill. Possibly as a result of a difficult *viva voce* examination, Dr Gee had a low opinion of Professor Bain. He is quoted by Dr Wickham Legge as saying ‘Yes, Mill was an able fellow, but Bain was a dunderheaded Scotchman’. Incidentally, Dr Wickham Legge was highly critical of the London University Medical Examination of those days. He said that he had heard the President of the College of Physicians, himself a doctor of that university, tell the College from the presidential chair that the examination for the degree of MD was a ridiculous examination by reason of its stringency. But Dr Legge also said that the only thing for which he felt in any way indebted to the University of London was for its making him go through a short course of philosophy before taking the MD degree. Should we not look again at our final examinations, comparing them to those of a hundred years ago, which certainly produced a good race of doctors. I am not suggesting that we should necessarily include an examination on moral philosophy, although I would not rule out this possibility. But I do suggest that we should consider if the technical aspects of medicine are not too much represented in our examinations at the expense of its basic scientific and wider cultural aspects. It seems to me that there is much to be said for a final examination in physiology to emphasise its continuing importance in the minds of doctors rather than physiology being regarded as something to be got over before the serious study of medicine begins. You will notice that I
ignore with contempt the concept of continuous assessment with its overtones both of the play group and of 1984.

The second point I wish to make about medicine in the latter half of the last century is a different one. I have now read all Dr Gee’s published work, mainly to be found in the volumes of St Bartholomew’s Hospital Reports between 1867 and 1906. As one opens these volumes one is pervaded by finely particulate London fog that begrimes fingers, wrists, and even nostrils. Thirty years ago the task of reading through these papers would have filled me with boredom and despair; but it is an interesting, and I think universal, experience of getting older that historical events become much closer and more real to one. In reality I should not regard Dr Samuel Gee as an historical personage. He was, in fact, six months younger than my father’s father, whom I remember very well indeed since he lived for considerably longer than did Dr Gee. There is, incidentally, one very tenuous connection between Dr Gee and my grandfather. Gee’s physiology examiners in the Final MB were Professor Thomas Huxley and Dr George Busk. Dr Busk was a distinguished naturalist who was best known for his analysis of the marine polyzoa obtained during the Challenger Expedition, and my grandfather was navigating officer on HMS Challenger. But to return to those dusty volumes, the point I wish to make is that the latter half of the last century was as exciting in medicine and general science as is the latter half of this century. The publication of the Origin of the Species when Gee was 20 would in itself justify this statement. The telephone, electric light and wireless telegraphy were all introduced during Dr Gee’s working life. My grandfather started his naval career in wooden sailing ships and as an old man was offered, but prudently declined, a flight in an aeroplane. These events are, I think, at least as exciting as those of our day which have led to our invasion but not, I am glad to say, conquest of the moon.

In medicine there were equally impressive advances and it is easy to recapture the pleasurable anticipation with which subscribers to St Bartholomew’s Hospital Reports, at 7s 6d per annum, opened their brand new instalments of the journal. There were particularly important developments in pathology due to the introduction of new analytical chemical methods and the ever-increasing power and use of the microscope; hardly a year passed without the discovery of a new bacterium as an explanation for previously obscure contagious disease. New diagnostic measures during Gee’s life included the introduction of the ophthalmoscope, the laryngoscope, the sphygmomanometer, the clinical thermometer, lumbar puncture, the detection and the significance of leucocytosis, and, ten years before he retired, X-rays. Advances in therapeutics were equally dramatic. Anaesthetics were first introduced when Samuel Gee was still a child, antiseptic surgery when he was a young
man. I came across one paper by Dr J. Morrison in *St Bartholomew’s Hospital Journal* for the year 1900 on the topic of Caesarean section. He wrote, ‘Before 1880 we may consider that Caesarean section was tantamount to death’. He contrasts this with the vastly improved survival rates following the acceptance of Professor Max Sänger’s new method of suturing the uterus; in a series of 35 cases reported from Leipzig there were only two maternal deaths and, incidentally, only two infant deaths.

It is sometimes said that from the beginning of time there were only six effective drugs until the introduction of antibiotics, but this attractive belief is untrue; a number of highly effective drugs were introduced during Samuel Gee’s lifetime, including chloral hydrate, the barbiturates, aspirin and heroin. Vaccination against smallpox had, of course, been practised long before Gee was born, but vaccination against typhoid was introduced in his lifetime. Dr Gee made his own contributions but he was not a great innovator. Perhaps one could liken him to Brahms rather than to Beethoven. Moreover, I get the impression on reading his papers that he was sometimes slow, perhaps even a little reluctant, to make use of the technical innovations of his day. The last edition of his justly famous book *Auscultation and Percussion* was published in 1908, four years after his retirement and three years before his death. In the preface he makes this reference to X-rays which had been introduced as a diagnostic measure about fourteen years previously:

‘The time has come when skiagraphy by the Röntgen rays must be reckoned among the methods of physical examination of the chest; but for several reasons the topic has not been included in this book. Hitherto our examination of the chest has needed no other means than those with which nature has provided us; but skiagraphy requires expensive apparatus which few care to possess. Moreover, a skiagram often needs interpretation by a person with large and special experience such as can be attained by few; for after all, it is seldom really necessary to call in the assistance of X-rays.’

Nevertheless, Dr Gee was without doubt a great physician and, because he also happened to be a great teacher, had a wholly salutary influence on medicine in his day, an influence which has perhaps lasted until now. He was an empiricist rather than a theorist, observing and learning all his life in the wards and the postmortem room. His attitude is best conveyed in his own words from an address he gave to the Abernethian Society in 1877.

‘For my own part, I do not rate German medical books very highly. It may be a fault or failing of mine; but, to speak plainly, they are not to my
taste. Time was when I followed the example of the many, and supposed that the secret of science was in Germany. I read many of their books with an honest intent, but I came to see that, for the most part, they were pervaded by two faults. The first fault was that syllogistic spirit of system which has led many of their best writers to think out over their desk symptoms of disease and methods of treatment, which the spirit of truth at the bed-side will not acknowledge. The other fault was the endeavour to say all that can be said, forgetful that there is a proportion between facts as between everything else, and that some facts are of great value, and others of little or none at all. This is a very old defect of the Germans. Montaigne alludes to it when he says "The Germans drink almost indifferently of all wines and liquors with delight; their business is to pour down and not to taste".

In his paper 'On the Nature of Asthma' he wrote, 'How often are we tempted to exclaim with the surgeon in the old novel, "A fig for reason, I laugh at reason; give me ocular demonstration". I cannot place that quotation; I thought it might come from Tristram Shandy, but the Harveian Librarian who knows the work backwards says no. Dr Gee is also quoted as saying, 'Anatomy, not physiology, for in anatomy you have facts; in physiology more or less theory.' Dr Charles Fletcher told me that Dr Gee's first words to Sir Henry Dale when a medical student at Bart's were, 'Mr Dale you can now forget all the physiology you have learned'.

Incidentally, Dr Gee's empiricism in no way prevented him from experimenting in therapy and a good example of this is provided in his paper on 'Acute Pemphigus'. He treated a vesicular rash on each of the four limbs of a four-year-old child with a different medicament, concluding after the 17th day that linimentum calcis (calcium hydroxide in olive oil) was unquestionably a better application than silver nitrate, zinc ointment or cotton wool. What Dr Gee did was to make meticulously careful clinical observations and to write them down in his notebooks; these are a model of methodicality. He had a basically simple but effective system of cross-referencing that enabled him to collect together for publication cases that showed similar features. Naturally, clinical observation by itself is valueless; it has to be related to something else about the patient that cannot be learned in a single bedside examination. As I have said, Dr Gee did not appear to make full use of new diagnostic measures in analysing and sorting his clinical observations, but he did relate these to prognosis, on the one hand, and to morbid anatomy on the other. The importance he attached to what we would now call follow-up examinations and also to autopsies is best conveyed in his own words which
throw a rather dismal light on the social circumstances of his day. ‘Contrasting hospital practice and private practice, we may say that the main advantage of hospital practice is the advantage it affords of examining the bodies of patients after death. The main advantage of private practice is that you know so much more about your patients during their life than you can by any means discover about persons who flit through a hospital and vanish into the darkness whence they came’.

It is obvious that certain advances in diagnostic measures, for instance X-rays, have to some extent detracted from the value of physical signs. Nevertheless, it is, I believe, true that history-taking and clinical examination, carried out so painstakingly by Dr Gee, are as important today as they were then. In fact they have added importance because bedside findings can now be related to the results of laboratory tests which give the former added significance. Young men and women starting out on medical careers could with advantage study Dr Gee’s system of private note-keeping, and adopt it.

Most, but by no means all, of Dr Gee’s published work is about diseases of children. The population of children’s wards is today, fortunately, very different from that of 110 years ago when Gee qualified, but it is interesting to reflect that most of these changes have taken place in the past 30 rather than in the previous 80 years. Gone are the chronic suppurative diseases, tuberculous meningitis and, to a large extent, acute rheumatism, which figured so prominently in his writings. One might conclude that the work of paediatricians had been correspondingly reduced. No doubt a number of explanations will readily occur to you to account for the fact that we claim to be harder worked than ever. However, one of the most important explanations is provided by entry 882 in Dr Gee’s 5th notebook, ‘Civilization tends to diminish acute diseases and increase chronic’.

In Dr Gee’s writings there are a few hardy paediatric perennials in the understanding of which little or no progress has been made in the past century. Several of Gee’s lectures were written up by himself or his house physicians for St Bartholomew’s Hospital Journal. Inevitably these include one on enuresis and, while Dr Gee has nothing strikingly original or profound to say about this tiresome condition, at least he says nothing foolish about it. The closing remarks of his lecture read as follows: ‘I knew a boy aged nine for whom circumcision was recommended and performed, not because he did wet his bed, but lest he should do so. Six months afterwards he began for the first time to wet his bed’. As another example of his good sense and refusal to be swayed by fashion let me quote the following: ‘Take Boerhaave’s aphorisms for a standard of knowledge at the beginning of the 18th century, and you will find that teeth and worms, like two inauspicious planets, still rule the sphere of children’s
diseases. And mark the simplicity of this pathology—until two years of age, or a little later, children are breeding their teeth; afterwards, worms become common; so that, between the one and the other, we never need fail for a diagnosis’.

A medical generation ago Dr Gee’s name was best known in connection with Gee’s linctus compounded of extracts of the poppy, a balsam tree and an onion-like bulb. As it contains two expectorants and one anti-tussive it is unfashionable today, as it is widely but erroneously supposed that a conjunction of soothing and stimulating qualities is unnatural. Today Gee’s name is best known in connection with Gee’s disease. His paper ‘On the coeliac affection’, published in 1888, was a masterly differentiation of this condition from other intestinal disease, particularly tuberculous and dysenteric enteritis, and Gee clearly recognised that the treatment was dietetic although it is interesting that he recommended abstinence from rice, sago and cornflour as well as other farinaceous food. He quotes one child who ‘was fed upon a quart of the best Dutch mussels daily, thrrove wonderfully, but relapsed when the season for mussels was over; next season he could not be prevailed upon to take them’. I suppose that with a quart of mussels inside one every day there would not be much room for anything else. This paper on which Gee’s current reputation is largely based was of only four octavo pages.

Coeliac disease is still sometimes known as Gee’s disease, but it is interesting to reflect on what other diseases of children might have been so eponymised but for accidents of fate: there are at least six other conditions. The establishing of priorities is always a difficult and hazardous task. Gee himself recognised this in a learned and amusing address that he gave at the Annual Meeting of the British Medical Association in Liverpool in 1883. The subject was ‘A survey of the literature of the diseases of childhood’. It is clear from this and other publications that the seventeenth century physician Glisson was one of Dr Gee’s medical heroes. He said of him:

‘Glisson marks the beginning of a new epoch in the knowledge of children’s diseases, and may be said to hold a place like that of Vesalius in human anatomy, of Harvey in physiology, of Morgagni in morbid anatomy, and of Laënnec in semeiology. There can be no doubt that Glisson discovered rickets, yet he was not the first to print a book upon the subject. He spent more than five years in writing his treatise, and he was helped by other Fellows of the College of Physicians; so that rickets had been much talked about before the appearance of Glisson’s book, and he was forestalled by those who had the pen of a ready writer. What shall I say of Daniel Whistler, who in 1684, published in London an essay upon rickets, which
he pretended to be a reprint of an academical thesis which he had first published in Leyden in 1645, or five years before Glisson’s book appeared? I cannot help thinking that too much trust has been put upon Whistler’s word of honour. Dr. Norman Moore, some years ago, caused inquiries after this alleged thesis of Whistler’s to be made at Leyden, and he tells me that they know nothing about it there. It was in 1684, the year wherein Whistler published his essay in London, that he died in well-deserved disgrace, having robbed the College of Physicians, of which he was then President. Wherefore, in that year, his word of honour was about as trustworthy as a dicer’s oath. In short, Dr Moore believes, and I agree with him, that Whistler’s academical disputation of 1645 may be but another of Whistler’s frauds.’

There is an article—just as amusing and even more learned—in the College Journal for April 1967 in which Dr A. M. Cooke convincingly clears the character of Dr Whistler in respect of plagiarism, although he cannot clear him completely on the charge of financial defalcation.

But to return to Gee’s diseases; one difficulty in establishing priority is that he, like many other writers of his age, did not think it necessary to refer to other publications on the subjects of his papers, although it was quite clear that he read a great deal, including the French and German literature. There was nothing dishonest in this; it was simply that he believed in the virtue of setting out his own personal observations rather than re-presenting the findings of others. For instance, in his paper on respiratory croaking of babies (1884), a condition we now call congenital laryngeal stridor, he says, ‘There is a much better description of this disorder in Rilliet and Barthez’ book Des Maladies des Enfants under the name of “Tracheite de la première enfance”; but in my description I have chosen to rely wholly upon facts within my own experience’. Nevertheless, I wonder if in writing his paper on ‘Purpura in Chronic Nephritis’ in 1880 he had read Dr Henoch’s article published six years earlier in the Berliner Klinischer Wochenschrift, for it is clearly the same condition and in the three cases he describes the nephritis was only chronic in the sense that the children left hospital with persistent albuminuria. But if anaphylactoid purpura cannot justly be called Gee’s disease, what of the following?

In 1884 he published a paper on ‘Idiopathic dilation of large intestine’ and two of the three boys whose cases he presented quite clearly had Hirschsprung’s disease; Gee even reports ‘spasmodic stricture’ at the lower part of the sigmoid flexure and the upper part of the rectum. Gee does refer to three previously published descriptions of similar but not identical cases, but Hirschsprung was not to describe the condition until two years later. There are short papers on
'Head Shaking' and 'Head Banging', published in 1886. Gee differentiates these two conditions, and the former is an early, but not the earliest, description of spasmus nutans. This condition is unusual today; not so head banging, which is another paediatric hardy perennial and which Dr Gee was, I think, the first to describe. This is what he says of one of his three cases, a two-and-a-half-year-old boy, 'At night in bed, both when awake (? half awake) and when sound asleep, he would turn over on to his face and bang his forehead into the pillow. In this way he sometimes behaved nearly all night long; in which case, it need hardly be said, he awoke very weary'. Is there a better early description of athetosis than that of case III Margaret B. aged 8 years in Gee's paper 'On spastic paraplegia', published in 1877?—certainly not in William Little's famous paper published 15 years before nor in the more detailed reports of Sigmund Freud which were not to appear for another 15 years. Here are some extracts from his description of this case. 'Intelligence: probably natural; can speak; is clean in her habits. Face: articulation imperfect; when she speaks, her mouth moves like a case of chorea; occasional meaningless contraction of muscles of face. Rigidities:' (this is a beautiful observation!) 'when the arms and legs are observed, they become stiff. Arms tend to be brought forward at the shoulder, and rotated outwards; elbows strongly extended; wrist pronated; hands extended strongly, and thrown back at wrist; fingers flexed, she can move the opposing muscles, but with difficulty; and the arms soon relapse into the state described. The constant strife between the rigidities and voluntary movements causes a sort of chorea. Chloroform, given to unconsciousness, removes all the rigidities'. Since Dr Gee clearly did not differentiate this case from the other cases of spastic diplegia which he describes, perhaps athetosis should not be included in the list of Gee's diseases.

However, was Dr Gee the first to describe nephrogenic diabetes insipidus? In a paper published in 1877 he gave a brief account of eleven patients, adults and children, in four generations of one family. It is quite clear from his description that the condition was inherited as an X-linked recessive. One extract from the paper reads, 'Patient number eight cried for many hours after his birth, and could not be comforted. His mother soon suspected that he might perchance be tormented with the family thirst, and she begged her nurse to give him some water. At first the nurse refused; afterwards she gave water to the child, and straightway his cries were stopped for the time. He died at six months of age, and of suffering from thirst'. Gee is generally acknowledged as being the first to describe what we now call cyclical vomiting but which was more felicitously termed by him 'fitful or recurrent vomiting', in 1882. He certainly believed himself to be the first to recognise the connection between chronic otitis and meningitis rather than cerebral abscess. 'Whether
this truth’, he says, ‘be generally known or not I cannot say; this I can say, that the books of reference in common use (for instance, Rilliet and Barthez’ work) do not allude to the coincidence in the remotest manner’. In 1878 he published with Dr Thomas Barlow a paper entitled ‘On the cervical opisthotonos of infants’. They described 25 cases and the postmortem finding of postbasic meningitis, which we now know to have been chronic suppurative, mostly pneumococcal, meningitis. And finally, in what is I feel an incomplete list, I must mention his paper entitled ‘On phrenitis aestiva’—acute delirium with fever that developed in four children during hot summer weather. All four had vomiting, with or without diarrhoea: all had high fever: all had cerebral symptoms, convulsions, delirium or coma. Two of the children recovered but had persistent and gross cerebral dysfunction. Of the two children who died a postmortem examination was carried out on one, and the principal finding was small black clots in the sinuses of the dura mater. If Dr Gee is not given the credit for what is surely the first clear description of hypernatraemic dehydration perhaps it should go to Hippocrates. He says that he turned to the *Epidemics* books 1 and 3, and ‘found cases resembling his as closely as cases could’. The description includes the information that the urine was black, (he puts in brackets ‘dark, high coloured?’), scanty and thin.

These were by no means Gee’s only published contributions to paediatrics. I will mention just one of many more—his careful analysis of the circumstances under which children had convulsions. In a study of 102 children he claimed that in no less than 56 the existence of a constitution tending to rickets was the most important fact in the kind of convulsions in question. The correctness of this view has only been confirmed in this century when the higher incidence of convulsions in children between the ages of six months and two years of age disappeared as free supplies of cod liver oil became available from infant welfare clinics. Incidentally, in another paper on rickets Gee says, ‘In cod liver oil we possess a pharmaceutical agent worthy of a place beside iron, Peruvian bark and mercury’.

Of course, not all Dr Gee’s published works are models of prescience and he sometimes classifies together disorders that in the light of subsequent knowledge we know to be heterogeneous. His paper on ostial or periostial cachexia is, according to my colleague, Mr Malcolm Gough, a complete muddle and should not be used to enhance his reputation. Because of my own interest in hyaline membrane disease I turned with trembling fingers to a paper entitled ‘Extreme and fatal dyspnoea in newly born children’, but alas I could make nothing of it.

There is one other aspect of Dr Gee’s life to which I would like to draw attention, and that concerns his attitude to the work of a hospital physician.
This quotation from one of his notebooks not only illustrates this attitude but also his delicate precision in the use of the English language. ‘There is no name that I hate, yet there are two names that my soul loatheth’ (he has crossed out the word loatheth and substituted abhorreth) ‘... there are two names that my soul abhorreth; the name of a specialist and the name of a consultant’. Dr Gee resolutely refused to be called a children’s specialist and, of course, the title of this lecture which with his classical erudition he would have had no difficulty in understanding would have seemed both strange and repellent to him. In a lecture to the British Medical Association he quoted from Alexander Pope’s *Essay on Criticism*: ‘One science only will one genius fit; so vast is art, so narrow human wit’. And he goes on to say:

‘But art is not yet so vast, nor human wit so narrow, that the diseases of children need be made a speciality; and I believe that none of us are specialists in the popular and evil sense of the word. For my own part, if I may speak so much of myself, being physician to a hospital for children, and to a much greater hospital for people of all ages, I can see that my knowledge of children’s diseases would be much poorer and meaner than it is, were it not for the larger experience I gain at St Bartholomew’s. I wish that the governors of the general hospitals would make more provision for sick children, and then the need for special children’s hospitals would pass away’.

His wish has, at least in part, been fulfilled.

In Dr Gee’s youth children’s physicians were by and large obstetricians. For instance, Dr Charles West, the founder of the Hospital for Sick Children, Great Ormond Street, and Dr Gee’s chief there, was obstetrician at the Middlesex Hospital. Incidentally, Dr West was one of Gee’s examiners in the Final MB in midwifery, and it is interesting that the written paper contains no questions at all about the newborn baby. Dr Gee and a few others in his generation began a new style of paediatrician, one who was basically a general physician, and his wishes that this state of affairs should remain were fulfilled until very recent years, and even today paediatricians are in a sense the only general physicians left. If you regard that statement as untrue, or, if true, arrogant, I would point out that few individuals who are called general physicians are consulted, as we are, about patients with neurological, dermatological, psychological and even orthopaedic disorders. It now appears, however, that paediatricians are to become specialists. Whatever one thinks of the pros and cons there is a sort of inevitability that this development will come about. I do not propose to start an analysis of the virtues and defects of specialisation of various degrees. In the past hundred years medical writing
has been punctuated by shrieks of anguish from elderly physicians and surgeons concerning the evils of specialisation, unwilling perhaps to contemplate the upsurge of a new generation of doctors possessing expertness and knowledge not within the grasp of their elderly arthritic fingers. I do not propose to add the feeblest of shrieks but only to murmur that there are perhaps certain virtues in some individuals remaining widely based in medicine. However, I do like to think that the future will bring a strengthening of that part of medical practice in which most paediatrics is done today. I refer, of course, to general practice. It needs a new attitude to paediatrics in the undergraduate curriculum and it needs certain arrangements that would enable all general practitioners to obtain experience of paediatrics as hospital residents. I believe that the sum total of paediatric knowledge necessary for effective work in general practice is well within the capacity of an intelligent man and woman who remains a family doctor. At the same time, let us not make the training requirements of our paediatric specialists too rigid. The Specialist Advisory Committees of the Joint Committee on Higher Medical Training will, I have no doubt, be imbued with the desire to remain flexible in their assessment of a candidate's postgraduate experience for purposes of accreditation. Nevertheless, I can see case law arising and rigor mortis gradually setting in. Do let us leave room for the entirely unconventional training and do let us avoid the rigid delineation of specialties. To give one example, I believe that the care of the newborn in hospital is best accomplished by the paediatrician, but is there not a case for a few obstetricians abandoning gynaecology in favour of neonatal paediatrics? I know that many of my paediatric colleagues would accuse me of selling the pass so recently and painfully won from the obstetricians, but I do not believe that we, that medicine, and, most important, that our patients will suffer from a little intra-professional competition.

And now a last word about Dr Gee. I have told you enough about him to persuade those of you who do not know him already that he was a great physician. It is also evident that he was a man of rigid honesty, high conscientiousness, great learning—both in medicine and in literature—and very considerable wit. All in all he is a man I would greatly have admired. Would I have found him a man after my own heart? Alas, I think not altogether! I suspect that I would have shared Charles Lamb's feelings about one of our island's races—imperfect sympathies. To say this is to say nothing derogatory about Dr Gee any more than Lamb really intended anything derogatory about the Scots. Thus, I am not offending against the injunction De mortuis nil nisi bonum nor is there any need for me to invoke Dr Samuel Johnson's famous aphorism about lapidary inscriptions, surely equally applicable to memorial lectures. To explain what I mean would tell more about me than it would about
the subject of my lecture, and I intend self-revelation in this lecture to be on a purely subconscious basis. Dr Gee was a somewhat taciturn man who chose his words very carefully and who did not make friends easily, but those friends he had remained close, devoted and faithful. Perhaps it is sufficient to say that my family motto is *silentiumvirtusstultorum*, and silent though Dr Gee was, no one could ever have accused him of being a fool.

I should have liked to have ended my lecture with a piece of verse from Robert Bridges, the Poet Laureate who was a Bart’s doctor, junior to Dr Gee, a close friend of his and, in fact, best man at his wedding. Robert Bridges did write verse to his friends including Sir Thomas Barlow. Unfortunately, his only offering to Dr Gee is in Latin and, according to Mr John Griffith, Dean and Classics tutor at Jesus College, Oxford, the Latin verse would only score a very low $\beta$ on a charitable assessment and a critic of Bridges’ day would not have gone above $\gamma +$.

‘Quis venit ille autem gracilliscumtusque capillos,  
*Grandia terga sequens*, dimidioque minor?  
*Tutे, Gei.*

(‘But who is this coming, slender and sleek-haired, following the big men, himself but half as tall? It is you, Gee.’)

Mr Griffith tells me that the words ‘*Grandia terga sequens*’ would obviously suggest ‘following big backsides’. The last two lines read:

‘Tu nisi et exemplum mihi consiliumque fuisse  
*Rideret rapida me schola docta fuga.*

(‘Had you not been my guide, philosopher and friend, the learned school of medicine would be jeering at my headlong retreat.’)

I must leave it for a future and more learned Samuel Gee lecturer to make a new translation both from Latin to English and, I suggest, from English to Latin.

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