They therefore attend the surgery complaining of any of a number of symptoms remote from the urinary tract and their urinary tract symptoms and signs are discovered only on enquiry.

Urinary Tract Symptoms

Frequency of micturition	35
Renal tenderness to percussion	26
Pain (scalding) on micturition	14
Hypogastric ache	14
Renal ache or pain	12
Urgency	9
Hypogastric tenderness	7
Infrequent micturition	5
Foul urine	5
Stress incontinence	4
Difficulty of micturition	3

Also complained of were lack of desire to micturate and haematuria.

Non-urinary tract symptoms

Frontal headache	20
Abdominal bloating	18

(The patient complains that the abdomen is distended and that she feels about six months pregnant. This distension is apparent to the observer).

Unilateral or bilateral sacroiliac pain	15
Tiredness	12
Pallor	9
Depression	6
Irritability	6
Insomnia	4

Also complained of were loss of libido, dyspareunia, nausea and epigastric pain and slight general oedema in the absence of albuminuria.

The foregoing non-urinary tract symptoms are so frequently noticed as presenting symptoms of urinary inflammation that in this practice it is customary to look for urinary tract inflammation in all patients presenting in this way.

It is apparent that frontal headache, abdominal bloating, sacro-iliac low backache and depressive and psychological symptoms such as tiredness and irritability are particularly important. I would also draw attention to the importance of light percussion with the closed hand over the renal angle[2] in bringing to light urinary tract inflammation.

I should like to express my thanks to the East Anglian Regional Hospital Board for a grant towards clinical investigation of urinary tract inflammation.

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DIAGNOSIS AND NAMING

Sir,

Dr Howie's paper on diagnosis (May *Journal*) is a neat exposition of the theme that, in general practice, naming is a less reliable predictor of action than is information-clustering. He goes on to suggest that difficulties ensue in establishing a common clinical language between hospital and community practice as a result.

However, such difficulties only arise if 'diagnosis' and 'naming' are regarded as synonymous, i.e. if 'diagnosis' is given the restricted connotation of 'naming'. This synonymity is implied by Dr Howie throughout his paper; and does less than justice to the hospital clinician.

No matter where the physician happens to practise—in hospital or outside it—every consultation confronts him with four questions: 'What is wrong?', 'Why has it happened?', 'What is going to happen?', 'What should be done?' The basis of his answers to all four questions is probabilistic; and their relevance purely predictive. Both hospital and community practice share this probabilistic basis of activity; and any divergence between them is more apparent than real.

Diagnosis is more than naming—and to use (or imply) the terms as coextensive is to perpetuate a clinical attitude which inevitably confuses both the student and the physician.

Naming is a necessary human activity:

1. Attempting to reduce 'content information' to 'sign information'.
2. Satisfying (at least partially) the human need (of the physician) to reduce uncertainty.
3. and, in some degree, essential to experiential learning.

In the process of problem solving the physician's mind constantly switches between the particular and the general; and any formulation of the general requires naming and classification. These are useful tools; but not to be confused with diagnosis.

Only when the distinction between naming and diagnosis is clearly kept can clinical method shed the restrictions produced by servitude to traditional nosology: and the physician think more freely about the diagnostic process.

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REFERENCE

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MICHAEL BALINT

Sir,

While staying with a friend I saw the March *Journal* with the editorial on Michael Balint.