A rose by any other name would smell as sweet

ENDO

William Shakespeare, the English dramatist, poet and actor is considered by many to be the greatest playwright of all time. Shakespeare contributed many words, phrases and sayings to the English language and most of them are still in use today.

The play, Romeo and Juliet, a tragedy written by Shakespeare, was first published in a quarto version in 1597. It tells the story of two young ill-fated lovers, Romeo Montague and Juliet Capulet, their relationship doomed from the start as they each belong to rival feuding families. The title of this editorial is part of a line from the play. Here, Juliet tells Romeo that a name by itself is meaningless and of no real significance. What matters is what something is, not what it is called.

Many different criteria have been used to assess, and various terms have been designated to categorise endodontic treatment outcomes. 'Success' and 'failure'[1] may be considered of historical interest but they are the most popular terms used. However, other terms, including 'tendency to heal', 'not healed' and 'regression'[2]; 'healed', 'healing' and 'nonhealed'[3]; 'favourable', 'unfavourable' and 'uncertain'[4] have all been used. Recently, the terms 'effective' and 'ineffective' have also been proposed[5].

Regardless of what endodontic treatment outcomes are called, it may be argued that it is purely semantics. Interestingly, given the liberty to exploit the terminology it may be possible to choose, in the clinician's favour, descriptors that are sufficiently lax or all encompassing to ensure that the desired treatment outcome is always achieved.

In theory, there is no shortage of words in the English dictionary that may, potentially, be used to categorise endodontic treatment outcomes. A Devil's advocate may throw into this terminology cauldron further permutations. How about 'desired' and 'undesired'; 'expected' and 'unexpected'; 'foreseen' and 'unforeseen' or even 'wanted' and 'unwanted', to name but a few? However, is the almost inexorable need to come up with newer terms really necessary? Is the hunger for it merely a soul-searching mission or a guilty wish for reflection? Is it change for change's sake or is there a real need? Are we just playing with the language? Is it going to enhance clarity or introduce further ambiguity? Is it clearing the air or only clouding the issue? Are the differences in terminology or the nuances too subtle for the patients to appreciate anyway? More worrying, is the search for newer terms a defensive move against an increasingly litigious public? Are our energies not better directed at advancing the frontiers to improve treatment outcome rather than being wasted on attempts to come up with newer terms to cover possible treatment deficiencies? After all, even with all of Shakespeare's contributions, ideal or definitive terms may not exist, cynics may sneer.

Obviously and befittingly, this editorial piece is being deliberately provocative. The search for other or more accurate terms is not totally lacking in merit nor is it not an interesting exercise. Nevertheless, is the seemingly relentless search for newer terms to categorise endodontic treatment outcomes in danger of being, to use another phrase from Romeo and Juliet, a 'wild goose chase'? After all, 'What's in a name? That which we call a rose by any other name would smell as sweet'.

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