

## An interview with Jorge Faber

- Editor-in-chief of the Journal of the World Federation of Orthodontists and former editor of the Dental Press Journal of Orthodontics.
- Associate Professor of Orthodontics, University of Brasília (UnB).
- PhD in Biology – Morphology, University of Brasília (UnB).
- MSc in Orthodontics, Federal University of Rio de Janeiro (UFRJ).
- Received the 2010 Best Case Report of the Year Award for the best case report published in 2009 in AJO-DO, among other prizes.
- Published over 70 articles in scientific journals.



*Normally, we lose ourselves among the many things we have to do. In dentistry, I know few professionals who can skillfully combine scientific research, teaching and clinical activity. Professor Jorge Faber is one of them. In fact, he goes far beyond, gives much of his time to deal with the arduous and delightful task of serving as editor of a journal. In this interview, Faber goes through all these activities he performs easily in face of all his intelligence, perfectionism, creativity and organizational pattern. In statistics, a strange taste I share with him, we would say that Jorge is an outlier, for sure he is not normal and the mouth seems too small for this Brasiliense.*

*One of these days, however, I was surprised when he anticipated a flight to arrive earlier in Brasília—his homeland—in order to study with his daughter. I realized then that Jorge is a caring father, trying to balance the father with the teacher, researcher, publisher, inventor and clinician. There is no social responsibility that does not begin in our own home. Home which he shares with Ana Paula and two children, Pedro and Carolina. Ana Paula, his wife, is Jorge's multidisciplinary support. They got married and had children still young and the little contact I had with him will not allow me even to imagine the major barriers they faced to form a beautiful family allied to professional careers this successful.*

*This is not all. Jorge, gentle in words and gestures, is a black belt in Karate and, although not so religious, he is a fan of Pope Benedict XVI. In the interview, it is apparent that his great masters now have him as an idol. Those who work with him, also. Those who know him, as well.*

*Of course he has faults. Friends say it would be massive suicide to invite him to play a soccer match, he is really bad on it. He was left then, to study. Jorge, who graduated at University of Brasília (UnB), got his masters degree in orthodontics from the Federal University of Rio de Janeiro, his PhD in biology from the UnB, where he is, now, an adjunct professor. After five years working as the editor-in-chief of the Dental Press Journal of Orthodontics, he recently assumed the post of editor-in-chief of the Journal of the World Federation of Orthodontists, after a selection process which involved 18 other teachers around the world—an honor for orthodontics of a third world country. Thankfully, not all good Brazilians become soccer players. For Achilles, the heel, for Jorge, the feet. That's good.*

David Normando

## CLINICAL EXPERIENCE WITH NEW TREATMENT METHODS

### When and why did you initiate performing the Anticipated Benefit orthognathic surgery? (Telma Martins de Araújo)

The Anticipated Benefit was an idea I had in 2004, and the first patient underwent surgery in the same year, with Dr João Milki, surgery professor at the University of Brasília (UnB). I received at my office a patient who was referred to me by the Emeritus Professor of Pneumology of UnB Dr Paulo Tavares, with a severe obstructive apnea syndrome. The doctor had thought of orthognathic surgery to solve the problem, because the patient

could not, in any way, use a CPAP equipment. During his first consultation, I realized the obvious. This patient, in particular, couldn't wait about a year and a half to perform surgery, since this is the average time that orthodontic preparation for orthognathic surgery requires.<sup>1</sup> Maybe in a year and a half he could be dead.

The patient was bearer of a dentofacial deformity with a Pattern II. So, he would need lower incisor retraction prior to surgery to increase the overjet and enable mandibular advancement. During the appointment itself, I thought about my experience with Class III compensation with retraction of all lower teeth (Fig 1). In this treatment modality, we can take the lower teeth, that are already in a com-



FIGURE 1 - The titanium miniplates may be used in the jaw to serve as anchors for retraction of all the lower teeth. With this, you can avoid the orthognathic surgery in patients who do not wish to submit to it. The experience with this type of treatment gave me conditions to plan the orthodontic treatment as a whole before the surgery, then, install the appliance and operate without the conventional preparation for orthognathic surgery. Avoiding the conventional preparation does not mean not preparing the case for surgery. In fact, we have with the Anticipated Benefit more involvement with the "preparation" for treatment planning.

compensated position, to a hypercompensated position.

If the lower incisor retraction in Class III compensation is possible, it should be even easier to perform the same retraction during the orthodontic preparation in Class II individuals, where lower protruded incisors are led to an appropriate position within the mandibular symphysis.

I proposed this alternative treatment to the patient during the first consultation, and he accepted it. After he left, I remember, vividly, being seated at my office thinking of other cases: Why shouldn't I also use this in that patient? And also in that other one? Come on. Why shouldn't I use this in all surgical patients? And so it all began.

#### **What are the benefits that you see in the Anticipated Benefit?** (Telma Martins de Araújo)

The advantages are many and almost all of them belong to the patient, not to the professionals.

The first and obvious is the, almost immediate, improvement in facial appearance. We have to remember that most patients submit themselves to a surgical orthodontic treatment because they want to improve their esthetic.<sup>2,3</sup> I used references to support this statement, though it wouldn't be necessary. Any patient or professional who is involved in the treatment of this type of condition knows it perfectly.

The second advantage is that the conventional treatment, mainly in patients with facial Pattern III, worsens facial esthetics considerably during the orthodontic preparation. This characteristic of conventional treatment repel many patients from receiving the surgery benefit and it is, somehow, paradoxical. The paradox lies in the fact that a treatment performed to improve facial esthetics has to, as a matter of fact, worsen it before improving. This entire process is justified because it does not only improve facial esthetics. Patients have important functional gains, of different natures, but it remains a paradox.

Another advantage, one that is not seen at the beginning, is the reduction in treatment time. I estimate that the total time of treatment fall about 40 to 50% in relation to the time needed for the

conventional treatment. Some also ask me if I think the result is different... That response is clear to me: No, I do not believe there is a difference. However, I keep here a caveat. The decompensation through conventional orthodontics—i.e. no skeletal anchorage—often under-decompensates the patient. The balance of this is that the surgical result tends to be smaller than the ideal. So, I think the outcome of both treatments tend to be equal, as long as in conventional surgical orthodontic treatment skeletal anchorage is used as a resource in many cases. Otherwise, I believe that the Anticipated Benefit tends to provide better results.

#### **What are the limitations of use of this technique?** (Telma Martins de Araújo)

There are a few, like the need for a longer learning curve by the orthodontist. I think that it is quite imprudent for a professional to start using skeletal anchorage in a surgical case. Only after treatment of various non-surgical cases by means of skeletal anchorage is that someone should treat the first patient with Anticipated Benefit.

The second limitation is that patients with Pattern II with good facial height (Fig 2A) and pronounced curves of Spee, hat will receive mandibular protraction, can remain with a lower facial height if we do not level the lower arch prior to surgery. If we do not intrude the lower incisors before surgery, the result of surgical treatment will be a face longer than ideal. So, if we intrude the lower incisors before the mandibular protraction—using mini-implants, for example—we will have a better treatment result (Fig 2C).

Additionally, in cases where the upper arch is very unlevelled, it can be difficult to plan the final position of the occlusal plane. In these cases it is indicated upper arch leveling prior to the surgery.

In all of these limitations, I do not proceed with conventional preparation for orthognathic surgery, I just align and level the teeth before performing it. Only after surgery I address anteroposterior correction, rotated teeth, etc.

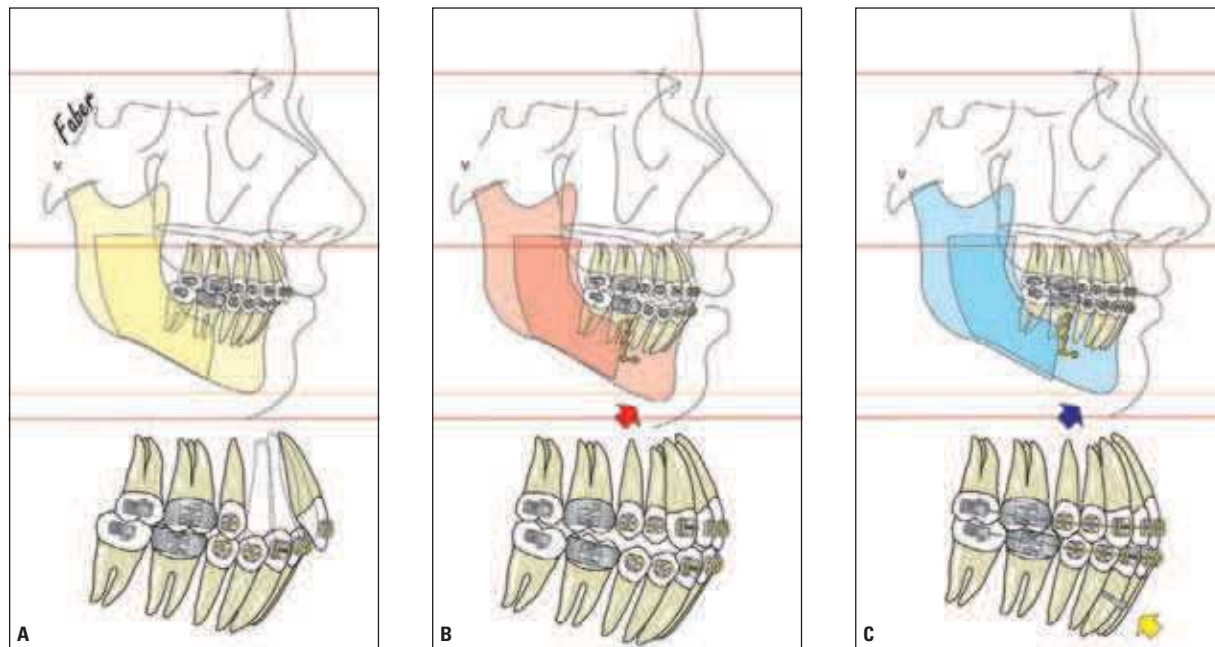


FIGURE 2 - Illustrations representing treatment alternatives for a Pattern II patient with normal face length, through mandibular advancement. The teeth below the cephalometric tracings present a magnification of the occlusal relationship in each of the three cases. The unlevelled lower arch with pronounced curve of Spee in patients with Pattern II and normal or increased face length (A) will lead to less than optimal esthetic result after surgery (B), because the mandible after being protracted will necessarily have the menton shifted downward in a final position (red arrow), while an open bite occurs in the region of pre-molars. This situation increases the lower portion of the face. Meanwhile, if the intrusion of the teeth is carried out previously, e.g. using mini-implants, we will have a final treatment result with better facial esthetics (C).

**Considering that you have been indicating the Anticipated Benefit in surgical treatments for quite a few years, what is your current view, from the perspective of accumulated experience through time?** (Leopoldino Capelozza)

The Anticipated Benefit is a daily reality in my clinic since 2004. When a patient comes to me, I always present the two alternatives and show results of treatment with them. Along these years I never had a patient who said: "I want to do the conventional treatment". The reasons are obvious and I already commented on them in another question.

I particularly think the use of this technique tends to grow even further. It came to stay. However, I cannot declare the concept as something easy to be done. It depends on a large skill on

skeletal anchorage, in particular, on the use of miniplates. This is perhaps the biggest drawback for the use of this approach by many professionals. In addition, it requires the orthodontist to understand surgical planning and be able to provide concrete opinions on it.

For the patient, the experience of treatment with the Anticipated Benefit is grossly superior to conventional treatment. This is not only because of the reduced treatment time but also due to immediate improvement in facial appearance and in respiratory function, when it is compromised leading to snoring and obstructive apnea.

If my son or daughter were to submit to orthognathic surgery, I would do the treatment with the Anticipated Benefit.



**What are the possibilities, in your point of view, of dealing with growth in Pattern II patients, mandibular deficiency, through forces applied in miniplates (bone-bone)?**

(Leopoldino Capelozza)

The orthopedic possibilities of using skeletal anchorage for the treatment of Pattern II are instigating. However, I see this alternative, as well as the Pattern III treatment with some concern. My concern with these treatment alternatives comes from my experience of over 700 miniplates installed in patients in my private practice.

The biggest complication of using miniplates is the infection in the region of the implant. Dra Taciana Morum performed her master's thesis evaluating the risk factors for infection in 139 miniplates installed in patients from my private practice.<sup>7</sup> It was noted that the increased plaque index on the miniplate is a strong predictor of infection factor. All sample patients were adults. So, some questions arise: What would be the expected infection rate if we were dealing with youngsters? What are the effects of these repetitive infections in teenagers? It is known by all orthodontists that plaque control in a teenage patient is something harder to be done.

So, my experience suggests that the complication rate perhaps requires the imposition of special measures of plaque control for these patients. Possibly monthly visits to a periodontist would be appropriate and perhaps the association of a chemical plaque control.

With plaque control properly resolved, I believe that we will have promising treatment results with these approaches.

**What are the main benefits and disadvantages of using miniplates to correct double protrusion?** (David Normando)

The main benefit is to avoid premolar extraction. In other words, it is not to negatively impact on patient esthetics during treatment. Evidences point to the fact that the orthodontic appliance does not hide extraction space and this space totally compro-

mises facial esthetics during the smile.<sup>5</sup> If we take into consideration that this treatment is motivated mostly by the esthetics, we are facing a conflicting situation for patients, and this drives many of them away from the benefits of orthodontic treatment. I'm sure all orthodontists already heard a phrase like this: "... and I searched an orthodontist at that time and he told me I needed to extract teeth, then I gave up. I'm here 10 years later because...".

The disadvantages are of two natures. The first is the need for another surgery: The removal of the miniplate. The placement surgery does not count here, because it equates to the surgery to remove the premolars. The other disadvantage is that it is a new procedure, that involves a learning curve to deal with the four major side effects.

Two of them always occur (Figs 3A and B), which are molar distal inclination and bite-opening in the posterior region. The other two are occasional: The crossbite tendency of upper molars (Fig 3C) and the emergence of a tissue excess in the lower retromolar region.

The first two are fixed with tip-forward bends, preventing or correcting the inclination. The contraction can be avoided with a transpalatal bar or other common means. The exceeding tissue is avoided with a lot of hygiene. On a few occasions it is necessary to perform a distal wedge surgery to remove the excess of mucosa in the area.

**Amid so many of your innovative proposals, perhaps one of the least known among orthodontists is the periodontium distraction with the aim of promoting periodontal bone regeneration. Almost 7 years after its publication in the *Journal of Dental Research*, how do you evaluate the current clinical use of this procedure?** (David Normando)

The Periodontal Distraction, name I gave to this technique, still is the approach that promoted the largest supracrestal periodontal regeneration described in the literature. We achieved a periodontal regeneration of 5.5 mm on

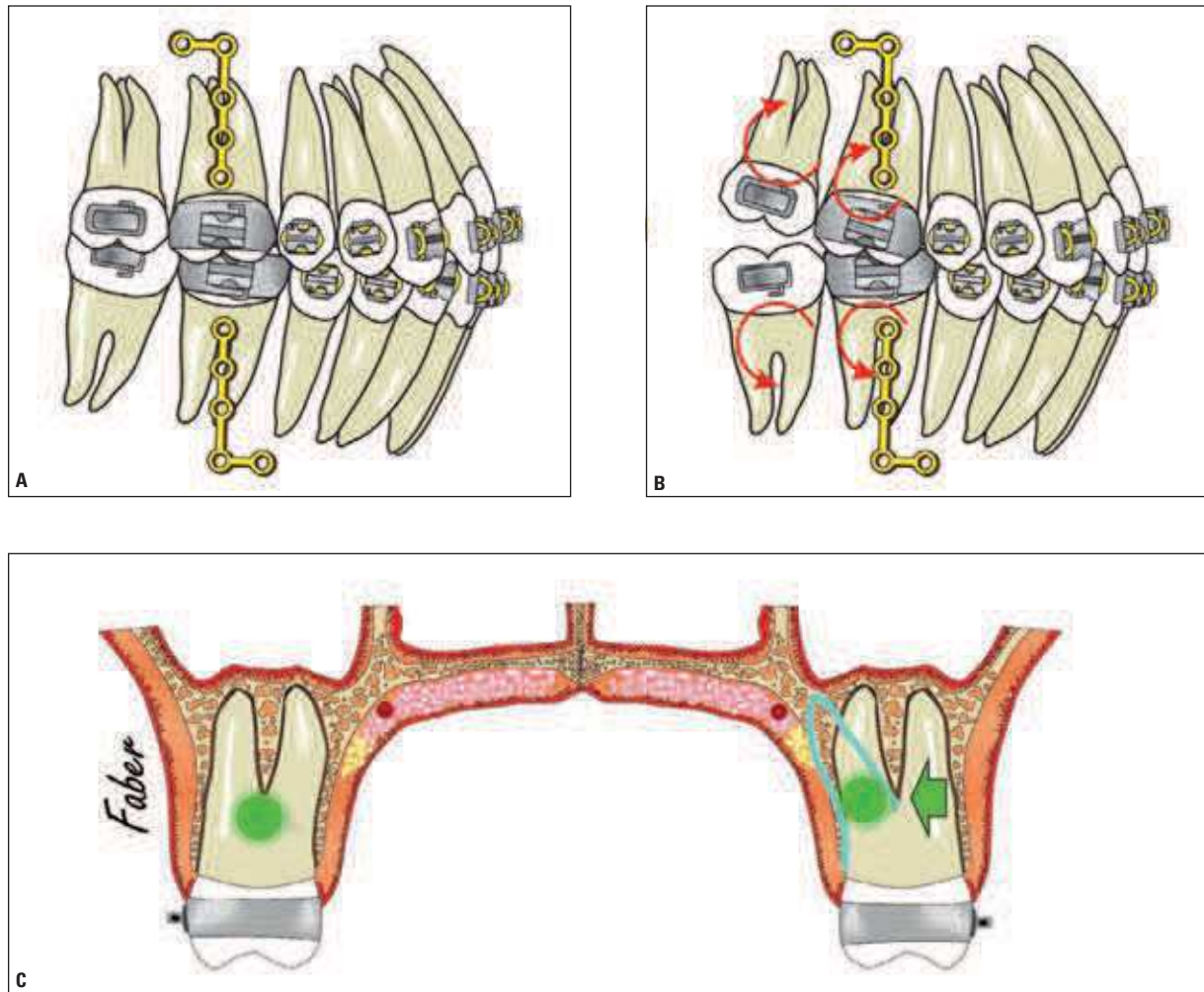


FIGURE 3 - Illustration representing the distalization process of the lower and upper teeth, during the non-extraction double protrusion correction. **A)** Teeth relationship before initiating dental movements. **B)** During retraction, molars tend to rotate around its own center of resistance, leading to a distal tipping and a posterior open bite as well. Both movements can be controlled with the tip-forward bends on molars. **C)** Teeth with too divergent palatal roots tend to move its center of resistance (in green) to the palate. This anatomic variation intensifies the crossbite tendency of upper second molars during distalization.

average, with a few areas showing a regeneration of up to 1 cm.<sup>8</sup> The procedure is promising. The experience I had in dogs and after treating two patients showed me that applying to patients is easier than doing so in the laboratory. However, I think there are two factors that explain why the technique does not please everyone.

The first is that its father, I mean me, did not continue working on it as needed by being involved with other clinical and academic activities.

I gave more emphasis to the skeletal anchorage and the Anticipated Benefit other than the Periodontal Distraction.

The second is that the implant culture is very deep-rooted due to a number of factors in our area. There is a tendency, refuted by many, of “sacrificing” teeth of an uncertain future in order to install implants. Part of it comes from the own intensity which implants are preached for both dental and patients universe.

In addition, there are strong financial factors. Companies and professionals are very interested in new materials which can be applied in the patient, sold as a product. The Periodontal Distraction regenerates the periodontium of the patient without any new glue, membrane or protein. It requires only one screw with a different design and that is cheap. This cannot be widely sold by a company.

**Considering your inventive and visionary genius, what do you predict after the mini-implants, miniplates, new technologies and materials, and advances in biology in relation to the optimization of orthodontic treatments?**

(Nelson Mucha)

Orthodontic treatment evolved fantastically over more than 100 years of the specialty's existence. We improved a lot the self-esteem and life quality of millions of people around the world, at the same time we contribute for the health of patients. However, we still have anchors that prevent us from being even more comprehensive and bring those benefits to an even greater number of people. This anchor is the appliance itself.

The fixed orthodontic appliance with brackets was developed by Angle seeking treatment effectiveness. Trying to increase the efficiency of treatment, the Straight-Wire and self-ligating brackets were developed. However, all of these advances were focused on the professional not on the patient.

The bracket was developed at a time when the patient's opinion was not considered. Today this is different. All professionals in the world have already heard from some of their patients, shortly after the appliance's assembly: "Doctor, you have to invent something more modern to do this treatment".

We need to go back to the drawing board to design something totally new in terms of design. The bracket is not an unchangeable icon. The aligners are a beginning, but they still aren't the solution. The orthodontic appliance needs to be more esthetic and less traumatic. This is the great challenge of orthodontics. And to accomplish this

task probably we need to throw away the orthodontic appliance design used today. It is likely that the orthodontic bracket is a future museum piece.

Although it is necessary to develop an appliance with a totally new design, it will not prevent that the information baggage created over the years continue. When moving the position of a tooth from A to B it does not matter if we did this via treatment alternative 1 or 2. Stability, esthetics and other knowledge will tend to be the same.

**When contemplating the news and evidence on (1) diagnostic procedures and means; (2) recording process (Cloud); (3) treatment planning; (4) executing; (5) conclusion and (6) stability of results, which constitute important steps in the art and science of orthodontics, it is questioned: In which one of them you predict the greatest breakthroughs and what kinds?** (Nelson Mucha)

Recently Artese et al<sup>6</sup> published an interesting work on the characterization of different open bites and its possible influence on treatment stability of this condition. They have raised an interesting question: Are all open bites equal? This characterization can lead to better diagnosis and treatment plans, and this naturally impacts over other stages of the treatment, including stability.

What the authors have done was to separate the condition in types, to analyze each one differently and, possibly, provide better and more specific ways of treatment. The next step is conducting randomized clinical trials to test the hypothesis of increased stability of these more specific treatments.

Now using this example to answer your question more clearly, we need to better understand the various malocclusions and deformities (improve diagnosis) to define exactly what are the best treatment alternatives for them (improve planning). This can only be done from studies with higher level of evidence, as randomized clinical trials. From this we will have a qualitative leap in the care provided throughout the world.

But, something needs to be said here. None of this will make sense if there will not be a strong action of educators to promote scientific evidence. Much of the information presented at conferences around the world lacks evidence or even are directly against the existing evidence. Old and obsolete ideas reappear on presentations of people who do not study enough to teach about it. We need to be more careful with this.

### **EXPERIENCE AS AN AUTHOR, REVIEWER, EDUCATOR, INVENTOR AND PUBLISHER**

#### **What basic advice would you give to a young researcher trying to have his first article accepted in a scientific journal?**

(David Normando)

A good article is always telling a good story. A good novel requires a good storyline and narrative. A good article, a good study design and also narrative. The young author often needs the help of a tutor so he can develop a study with a proper design and also ensure that the subject of the article is interesting, instigating. However, the narrative belongs to him, the author.

To write a good paper it is important to know that many reviews are necessary to achieve proper polishing and brightness. Even today, despite being totally involved with articles, when I write, I do several reviews. Typically, more than ten. Clinical or statistical results of a work may even be awesome, but if the article is not well written, including here language quality it will hardly be published. Can we trust the quality of a study from someone who did not even give his best to write the paper properly? Did this person lead the research with the same lack of criterion that can be verified in the low quality of writing? These are questions that editors and reviewers often do.

Another important issue is to be with an open mind to the criticism that will surely come. During the review process, several controversial or incomplete points are scrutinized by reviewers.

Never mistreat these considerations. On the contrary, see the criticism as a unique opportunity of growth, of ripening. We improve a lot as authors when we accept the criticisms willingly.

In addition, it is interesting to look at articles on the other side, i.e. the reviewer's. This experience is enriching. Offer to revise good articles for journals. We learn a lot with the improvement of the ability to criticize in a based manner. And finally, don't be afraid to try the publication. All recognized and experienced authors have articles rejected for publication. It is part of the game. Sometimes the article is refused in a journal and ends up being accepted in another of even greater projection.

#### **What do you want to suggest to update the scientific publications and make them more attractive, especially for the new generations, besides offering real contribution for scientific knowledge and for those who work in the application of that knowledge?**

(Frederico Salles)

We have to bring the reader to the production and evaluation of knowledge process. This mechanism is accomplished through some tools, commented in the answer to the first question of Dr Mucha, such as the assessment of articles by readers and the possibility of adding comments. However, probably journals will migrate to an even bigger interactivity than this.

When a reader completes the analysis of a paper we will work in a way so that he can include also his clinical vision on the subject. Something like "show your experience with this treatment", noting both negative and positive aspects of that therapeutic modality. The journals can also serve as a great discussion forum, like study groups. In this context, we may divide their difficulties in clinical diagnosis, planning and execution in the environment of the journal, enjoying the opinion of several colleagues around the world.

To gather all that thought in a single sentence: We need to increase the interactivity of the reader to the scientific journals.



**In a relatively short period of time you moved from a dental school student to an editor-in-chief of a major international publication, the Journal of the World Federation of Orthodontists. Meanwhile you defended a master's degree, a PhD, published several important articles and received the 2010 award for best case report published in the AJO-DO. In addition, initiated skeletal anchorage in Brazil and in the world to the point of having one of the largest global experiences; you were one of the first orthodontists to understand the importance of treating obstructive sleep apnea and to give courses on the subject; you were a pioneer in the use and disclosure of rapid prototyping in orthodontics; developed an innovative periodontal regeneration technique by osteogenic distraction; launched the Anticipated Benefit technique, which in my opinion, revolutionized orthognathic surgery; and was the editor-in-chief of "Dental Press Journal of Orthodontics", one of the few Brazilian scientific publications that compete with their international counterparts. What is the secret of how to use emotional intelligence to do so much in so little time?** (Frederico Salles)

In the emotional field, the secret is to keep yourself passionate for dentistry and patients as a young graduate and, as so, believe that anything is possible. I also learned something over the years: whenever someone is about to do something innovative, be sure of it! Because everyone will give you all the reasons in the world why you shouldn't do it. And even after demonstrating that something is viable and good, the criticisms are many. Over time, if ideas are good, they are assimilated. I've lived all this cycle with skeletal anchorage, just to mention one example.

This all becomes a little clearer with the reading of Kuhn.<sup>4</sup> Mature professionals are naturally settled to the procedures which they already dominate and they do not want changes to occur, young people are different.

In the field of struggling, well, it is no secret, there was a combination of many factors. The first is that I have always been curious and so an avid reader, and as a child I read about everything. At age of 14 I had already read all the Barsa encyclopedia that my father had at home, as well as a large collection of books that included several classics of world literature. In spite of having read a lot of trivia in Barsa (laughs), still being a teenager I started reading a text only if I could learn something from it.

The second factor is that I had a diversified training. I had experienced oral and maxillofacial surgery before becoming an orthodontist, and I took a PhD in biology, which expanded the publication horizons in the biological area. Today, it is clear to me that my diverse interest reflected in my training.

In this way, my dedication, my belief in myself, and the good education were very important for every step taken. But there is one ingredient that makes all the difference in terms of success of new therapies: planning. In any treatment, planning should be done very seriously in order to succeed. It means taking risks, but not being in danger. Any treatment involves a certain risk, that can be understood as the inherent failure rate in any procedure. To be in danger is not planning, by laziness, lack of time, or ignorance. Planning is what allows you to safely transgress borders and innovate.

And finally, I think it is very important to cultivate respect for other people. We can learn from anyone, from the simplest citizen to the winner of a Nobel Prize.

**One of our deficiencies as Brazilian authors of scientific papers, in my opinion, regards few prospective clinical work. If you agree, how can we improve and stimulate this kind of research that would lead to major scientific and clinical evidences?** (Nelson Mucha)

It is a fact that we publish much, but our studies can still improve the level of evidence. The reasons for this issue are rooted in different soils. The first is that many our schools of greater

development are relatively new. Among the oldest schools, in general the researchers of high production belong to the first generation of the school that publishes internationally.

An important stimulus to the increase in the number of articles with this quality has to come from editors. At the moment, it is up to the editors to filter more the information produced. Many articles published in the world literature does not help to clarify our ideas about treatment protocols. On the contrary, when a mismanaged study is published, it often adds noise to the information. The pressure of having articles rejected will, of course, make professionals seek the most appropriate study designs. While researchers continue to have space in journals with simple works, it will be difficult to boost them to evolve to more suitable study designs. The process is simple: prospective studies spend more time and energy than other kinds of tests, so why publishing a complex work when I can publish several simpler? And there is more. The two types of work count equally in the curriculum and funding agencies. Finally, we have to take into account that a prospective work in orthodontics typically requires many years to complete. Far beyond the duration of a post-graduate course.

**I have been following your professional career long-standing (1991) and I can say, without the fear of making mistakes, that you are one of the bright and promising young professional of world orthodontics. Much is expected from you, including large and pleasant surprises. So, what are your future plans as editor-in-chief of the Journal of the World Federation of Orthodontists?** (Nelson Mucha)

The JWFO is a strategic development for the WFO. It will be distributed free of charge for the approximately 8500 current members of the WFO around the world and our goal is to become an important source of information for these professionals. This alone is a great start: Start with more than 8000 subscribers.

The journal will adopt a concise model of articles in electronic format only, but will complement the content written with the use of many videos of interview. My intention with this approach is to infuse the heat of a congress with oral presentations and body language to the “coldness” of scientific articles. I think the authors will probably embrace this creative initiative that will give them the opportunity to expose with more intensity their work and their own image.

Besides, the JWFO offers the possibility of entering in the process of knowledge construction through comments and reviews of articles.

**How did you decide to translate most of the Dental Press articles into English as a second language? Was this change worth the effort and cost?** (David Turpin)

The evolution of DPJO into English was a process of natural selection, we had already reached the ceiling of impact that publication could achieve by being published in the Portuguese language. This issue was in my conversations with the publisher since I took the journal. However, the decisive step came under pressure from the indexer organs themselves.

To make this step real was not easy. We spent almost a year testing different translators who had the ability to perform a high quality job with the dental scientific English. We felt a great initial resistance from the authors, because many wanted to write their texts themselves. That resistance still exists, but is smaller. Our experience over hundreds of articles is that no Portuguese-speaking author was able to write alone an article that hit our quality criteria. Everyone needs some level of help, even those who worked abroad for years. We need a lot of tact to say that even an author who have a great experience in English is difficult to equate to a professional or a native level of the language.

The cost of these translations runs on behalf of authors. Since the beginning I figured it was fair and valid for the authors to bear these expenses.

The DPJO has a great penetration in Brazil and other countries of Latin America. By translating articles into English, the authors gain in two ways: It increases their international visibility, while maintain the internal impact, since we also publish a mirror of the official English journal in Portuguese. This is the bonus that the authors have, and it is real. We, on the other hand, have doubled our work. I think this is a win-win relationship. Everybody works more, but everybody wins.

**Do you see the need to publish portions of the new JWFO in other languages once it becomes established? (i.e., Portuguese, Chinese, or Spanish)** (David Turpin)

Some journals, as the PLoS ONE, has, let us say, some versatility with the language. They publish articles in English, however, native authors from other languages, after acceptance of the work, can see their articles also published in their native language. This task aims to increase the visibility of the work of the author in his own country, making it easier to read.

The international characteristic of JWFO maybe leads us to adopt, in the future, a similar system. This approach would tend to increase the interests of the authors of good articles on the journal, as well as publishing in two languages attracted authors to the DPJO.

**It seems as though educators and researchers are busy people and not always available to give the editor much time or attention. How did you manage to work with these talented individuals? In other words, what do authors and reviewers expect in return for their support of any journal?** (David Turpin)

Authors and reviewers want different things. The author wants recognition of his work, and this is natural. Thus, he wants to publish in a journal that has credibility, and setting out the result of his effort for the greatest number of people as possible. This metric can be partly obtained by the impact factor of a journal.

Reviewers are also generally, authors but this does not always occur. They donate their time to review articles by different reasons. One of them is to show his/her competence to the editorial board. This is one way that many competent professional increased in visibility on the specialty around the world.

In addition the review process is a fantastic study and we improve much as authors when we engage with it. The critical reading of an article makes a professional grow incredibly. However, there is one thing that needs to be said. Critical reading comes with pages of comments, criticisms and reflections. A reviewing that ends up with a reject recommendation and comes after a telegraphic text, typically speaks against the reviewer. It is a sign that he does not want to review the paper or does not know how to do it. In any of the situations he ends up being removed from the list of reviewers.

We at the JWFO have all ingredients to attract quality reviewers and authors. First, because we have the credibility of the organization which maintains this journal: the World Federation of Orthodontists. Second, because the JWFO was born in an odd situation. More than 8000 orthodontists from around the world will receive the journal at no charge as part of their membership to the WFO. Among these professionals, there are many of the most politically influential and scientifically competent. And, finally, the journal proposes to serve as a discussion forum, where each article will receive notes and readers' comments. In addition to this, video interviews are linked to several articles, allowing a greater exposure of authors and their work.

**Online publications still present a problem for many of the targeted readers. Do you think the 8500 WFO members are ready for this change? How will you get the attention of the most reluctant members who refuse to search using the JWFO?** (David Turpin)

The world has gone through an intense transformation regarding the consumption of information. When the iPad was released, in April 2010, the market received it with discredit. Few understood, at that time that, that the gadget was more than a big iPhone and that it would revolutionize the media consumption. Less than 2 years later, the tablets turned the world upside down (and the DPJO was the first orthodontic journal to be edited for the iPad in the whole world). Many Brazilian universities and schools give each student a tablet, containing all reading sources they will need in the course.

I strongly believe that it will not be the JWFO that will have to struggle to convince readers who reject reading in electronic format. Simply, those who do not leave their comfort zone and seek these information alternatives, very soon, will struggle to keep up to date even on the projects of the manager of their buildings.

When I was a child, the beginning of old age in spirit was not knowing how to switch on the VCR. Today, it is not having an account on a social network and not knowing how to handle a tablet. I am already trying to fight against aging. (laughs).

**What orthodontic topics are of greatest interest to the international clinical audience? Once identified, how can you stimu-**

**late WFO members to submit clinical material of high quality representing these areas of interest?** (David Turpin)

The goal of any area in health sciences is the development of secure protocols tested for use in the population. This search led to the emergence of the theory related to the evidence-based clinical practice. The higher the level of evidence of a paper, the more it tends to be accessed and cited.

There is, however, a bias in the interest of curious readers about the papers. Readers are interested in both the highest level of evidence and in those of lower level, such as case reports. These works represent the new. There are new techniques, new protocols, new appliances. Maybe the interest for the new is an intrinsic attribute to the *homo sapiens* and that has led us to create the world as we know it.

There are different ways to attract these two poles. One is to offer rapid publication. My intention is to work with few articles, making our files always somewhat empty. Another one, is the visibility that we hope to offer by means of assess to articles by their readers, similarly to what is done on YouTube, for example. Finally, all this may have brightness intensified by the use of social media. This is an important tool for marketing and dissemination of information.



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