their mothers had gained a better knowledge of childrearing practices.

Informed consent could sometimes be postponed

When informed consent would let participants know what intervention they are receiving, patients may accept receiving information after the trial is over. Boter and colleagues (p 86) evaluated a modified consent procedure in which full disclosure was delayed until after data collection. The delay did not reduce the recruitment of patients, their trust in doctors, or willingness to take part in future studies. A modified procedure should be considered when the additional treatment entails no risk, and when this treatment seems attractive to patients, they say. In a commentary (p 87), Dawson says that no ethical principle should be absolute; a requirement for full informed consent may prevent beneficial studies from being done. Informing participants in advance that some information may be withheld may increase their anxiety, and to say nothing may be preferable.

POEM*

Exemestane is better than tamoxifen in years 2-5 after breast cancer

Question Does exemestane improve outcomes in patients with breast cancer when treatment with it starts 2-3 years after diagnosis?

Synopsis Tamoxifen is the current standard of care for the treatment of oestrogen receptor positive breast cancer in postmenopausal women. Exemestane is an aromatase inhibitor (they block the conversion of androgens to oestrogen) and may be superior to tamoxifen in patients with metastatic disease. After 2-3 years of tamoxifen therapy, patients were randomised to receive exemestane 25 mg daily (n = 2380) or tamoxifen 20 mg daily (n = 2362) to complete a 5 year course of therapy. All of the women were postmenopausal, had normal renal and liver function, and had an oestrogen receptor positive primary breast cancer. Allocation was concealed and analysis was by intention to treat. Patients were re-evaluated regularly. The primary outcome was disease-free survival. The number of patients with death, contralateral breast cancer, or recurrence was lower in the exemestane group (183 *v* 266 (7.8% *v* 11.2%); $P < 0.001$). After three years, the likelihood of disease-free survival was 91.5% in the exemestane group and 86.8% in the tamoxifen group (absolute risk reduction 4.7%; number needed to treat for 3 years = 21.3). There were fewer deaths in the exemestane group, but this difference was not statistically significant (93 *v* 106). The risk of contralateral breast cancer was lower in the exemestane group (hazard ratio 0.44; 95% confidence interval 0.20 to 0.98). Exemestane caused more arthralgias and diarrhoea, but fewer thromboembolic events, less vaginal bleeding, and fewer muscle cramps than tamoxifen.

Bottom line Exemestane improves outcomes for postmenopausal women with oestrogen receptor positive breast cancer when given for 2-3 years after 2-3 years of treatment with tamoxifen.

Level of evidence 1b (see www.infopoems.com/levels.html). Individual randomised controlled trials (with a narrow confidence interval).

Coombes RC, Hall E, Gibson LJ, et al. A randomized trial of exemestane after two to three years of tamoxifen therapy in postmenopausal women with primary breast cancer. *N Engl J Med* 2004;350:1081-92.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Editorial independence at the *BMJ*

"Editorial freedom," is famously "the freedom to publish those of the proprietor's prejudices that don't upset the advertisers." That accurately describes the state of editorial freedom in many newspapers, but the *BMJ*'s editor has enjoyed great independence. The BMA has had a strong tradition of editorial independence, particularly since a celebrated dust up between the editor and the association half a century ago. Our independence will be illustrated next week when we publish some pungent criticisms of the association.

Much of the editorial independence has flowed from the editor also being the chief executive of the BMJ Publishing Group and on the same level as the secretary of the association. This is unusual, and the BMA has decided that the positions of editor and chief executive will be split and that the chief executive of the BMJ Publishing Group will report to the group chief executive (formerly the secretary) of the BMA. Where exactly the new editor will fit in the new firmament is not yet clear, but there is provisional agreement that new structures and processes will be needed to safeguard editorial independence.

Everybody supports editorial independence in principle, although it sometimes feels to editors as if the deal is "you can have it so long as you don't use it." Problems arise when editors publish material that offends powerful individuals or groups, but that's exactly why editorial independence is needed. Journals should be on the side of the powerless not the powerful, the governed not the governors. If readers once hear that important, relevant, and well argued articles are being suppressed or that articles are being published simply to fulfil hidden political agendas, then the credibility of the publication collapses—and everybody loses.

But editorial freedom—like clinical freedom— cannot be total. I couldn't turn the *BMJ* into a soccer magazine because I'd got bored with medicine. Freedom must be accompanied by accountability, and how best might both be achieved for the *BMJ*? The optimal answer is probably an oversight committee like that created by the American Medical Association after the firing of an editor of *JAMA*. The committee should comprise widely respected figures from medicine and serve as a buffer between the editor and the BMA, providing a judgment on the editor's performance and settling disputes.

Such a committee—and the committee that appoints the editor—should, I believe, include people from outside Britain. The *BMJ* is increasingly an international journal, and most contributors and readers are from outside Britain. The BMA is the legal owner of the journal but also a steward of the journal on behalf of a wider health community.

Ultimately, I suggest, editorial independence is a space in editors' heads, a complex function of their personality, courage, power, and the pressures they feel from owners, business people, and others. I hope that the BMA can—for its own good and that of the international community—make that space as large as possible for my successor.

Richard Smith *editor rsmith@bmj.com*