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[John Lowman responds:]

Contrary to Ian Mitchell's defence of john school, direct observation of the curriculum tells a different story. When Tom Barrett, a journalist, attended john school 4 years ago, one of the pupils asked, "Why doesn't Canada have government-regulated whorehouses?" One of the police officers present replied, "Because people view it as an immoral activity."[1] Another officer told the audience that prostitution is "slavery. They are forced to be there." Canadian research does not substantiate these sweeping claims (see, for example, Benoit and Millar[2]).

Furthermore, there is no evidence that the curriculum has changed in the intervening period. Earlier this year, as part of his honour's degree research, one of my students attended Mitchell's john school and concluded that "the way that sex work is projected is selective and inherently political."[3]

Although the nuisance aspect is on the agenda, the very moniker "john school" gives the game away. The target is the purchase of sex, not the nuisance component. If john school really does let johns decide for themselves, I anticipate that Mitchell will accept my offer to make a regular john school presentation on Canadian prostitution research.

As for Dawn Hodgins' call to help women leave prostitution, such a stance is no reason to abandon the women (and men) who continue to sell sex. One legitimate concern is that decriminalization might trap women in prostitution, with welfare payments being denied to those who want to leave the trade. However, New Zealand's legislation makes it illegal to cut a person off welfare if they refuse to prostitute. At the same time, prostitutes can work in situations where they are not vulnerable to serial killers. In contrast, by ruling out harm reduction strategies, the Swedish approach exposes prostitutes to harm.[4]

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Risks and benefits of β-blockade

P.J. Devereaux and associates[1] state that the current situation with respect to evidence for β-blocker therapy before surgery is similar to the situation that existed 12 years ago when estrogen replacement was widely recommended. I disagree. Estrogen has been implicated in the genesis of many fatal diseases, including breast cancer and thromboembolic diseases.[2,3] The same material risks do not exist for β-blockers. Furthermore, the authors do not disclose or discuss the theoretical or empirical life-threatening risks of β-blockade.

Devereaux and associates[1] also argue that the benefits of preoperative β-blockade in small studies completed to date are "too good to be true." They base this assessment upon the long-term benefits of β-blockade in coronary artery disease and congestive heart failure. However, for these conditions the drugs are administered over long periods, and in combination with many other drugs, to modify the long-term outcome of progressive and often fatal diseases. A more analagous situation is the relative risk of a myocardial infarction induced by another acute stressor, strenuous exercise. One study found that the relative risk of myocardial infarction during or immediately after vigorous exercise was increased 100-fold for habitually sedentary individuals.[4] Most of the patients whom I am asked to see preoperatively are sedentary and thus very likely to benefit from preoperative β-blockade.

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[The authors respond:]

Contrary to Stephen Workman's experience in treating patients perioperatively, our review[1] suggested that the true effects of β-blocker therapy in patients undergoing noncardiac surgery remain uncertain because of a lack of adequately powered, blinded randomized controlled trials (RCTs).

Members of our group recently reported results from a new RCT of perioperative β-blocker therapy.[2] The Metoprololol after Vascular Surgery (MaVS) trial randomly assigned 496 patients undergoing elective vascular surgery to receive metoprolol or placebo starting 2 hours before surgery and continuing for 5 days. This blinded trial is the largest perioperative β-blocker trial reported to date, with more than 4 times as many patients as an unblinded RCT by Poldermans and colleagues[3] of β-blocker therapy for vascular surgery. Those authors reported a statistically significant 90% relative risk reduction with β-