

MET Calls – A potential change for the future

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Dear Editor,

As I come to the end of my first year within the Australian medical system, I've taken time to reflect on what I have learned and observed during my time here—and how it may influence my future career upon returning to Ireland.

Medical Emergency Teams (METs) are an essential element of the clinical landscape within the Australian healthcare system. Typically, a nurse or concerned staff member can initiate a “MET call” when a patient meets certain criteria, such as seriously deranged vital signs, a pain crisis, fluctuating Glasgow Coma Scale (GCS), and so on. The primary role of the MET is to provide early, appropriate care to deteriorating patients. These teams are usually clinician-led and include a medical registrar, ICU outreach registrar, unit intern or house officer, and an ICU liaison nurse. METs are in place in two-thirds of Australian hospitals and attend to more than 14,700 patients each year¹.

In Irish hospitals, rapid response is typically provided by cardiac arrest teams. These teams are, by nature, reactionary rather than anticipatory—activated only once a medical emergency, such as a cardiac arrest, has already occurred. As part of the Health Service Executive's (HSE) efforts to improve patient safety and care, the National Service Plan 2025 was recently published². It outlines goals to enhance both the quality and efficiency of care. Notably, it includes a commitment to improving patient outcomes by consolidating the critical care outreach service. While the plan doesn't yet detail how this will be achieved, the implementation of a standardised MET system should be strongly considered.

In Australia, the use of MET systems, for surgical patients, has been shown to reduce both mortality rates and in-hospital cardiac arrests³. Between 2013 and 2015, Irish hospitals recorded an incidence of 10.3 adverse events per 100 admissions. Adverse events were defined as unintended injuries or complications resulting in disability at discharge, prolonged hospital stays, or death, attributable to healthcare management rather than the underlying disease. Over 70% of these events were considered preventable³. Proper implementation of a MET system within the HSE—similar to the Australian model—could help reduce preventable adverse events through timely and appropriate intervention.

Beyond the urgent provision of care, METs offer another significant benefit: they provide reassurance to more junior staff during on-call hours. Because MET calls are staff-initiated, the anxiety and isolation often felt by junior NCHDs when managing unstable patients alone is significantly reduced.

From my brief time here, I've seen first-hand the positive impact METs have on both patient care and staff confidence. I wonder is it time to consider their introduction at home?

Declarations of Conflict of Interest:

None declared.

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