

six months implementation in the MET hospitals was only partial.

Brindley *et al.* may not have put this trial into full perspective for your readers. At The Ottawa Hospital, after two years of MET, we now receive > 40 calls per 1,000 hospital admissions (compared to 8.7 calls per 1,000 admissions in MERIT), and > 70% of the intensive care unit (ICU) admissions from our inpatient nursing units are preceded by a call to MET (only 30% in the MERIT trial), both suggesting much more effective implementation than in the MERIT study. Coincident with MET introduction, we have observed a 60% reduction in unexpected cardiac arrests compared to pre-MET historical control years, 10% fewer postoperative major complications, and trends towards fewer readmissions to the ICU, fewer postoperative deaths, and a reduced hospital standardized mortality ratio.

The MERIT study was an enormous undertaking, but to evaluate an intervention it is necessary to adequately implement it. Unfortunately MERIT failed to completely do so, despite the investigators' considerable efforts.

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Reply:

I thank Dr. Baxter for his comments and commend him on outlining much-needed provisional Canadian data. Presently, albeit imperfect, MERIT is still the largest and best-designed published trial: 23 centres, > 100,000 patients, prospective and controlled.¹ Therefore, it currently deserves to dominate debate. Notably, both medical emergency team (MET)-hospitals and control-hospitals

had decreased rates of cardiac arrest. This does not mean MET did not affect patient-outcome, rather there may be many ways to achieve these goals. It also cautions against “before-and-after” methodology. Furthermore, MET-detractors are not arguing against rapid-response, just whether MET is the best way to provide it. Respected authors have highlighted that MET criteria might be improved upon; that MET implementation might distract from other issues; and that critical care medicine is increasingly responsible for even routine acute care.^{2–4} Medical emergency team was a commendable first-step, but we need to acknowledge that it is also filling a void caused by over-worked and under-resourced nurses; an insufficient number of monitored beds; inadequate communication, and decreased “patient-ownership”. To not concomitantly address these problems is inconsistent with optimal patient care. Medical emergency team is fast becoming an unproven expectation. Medical emergency team implementation may also irrevocably change physician-training, physician-accountability, even the nature of critical care medicine. Furthermore, how we respond to difficult debates says a lot about our specialty. This includes how we treat research findings that challenge what is entrenched, popular, or expedient. Unfortunately, presently, much of the evidence supporting MET implementation is circumstantial. Equally, both proponents and opponents rely upon preconceived beliefs as much as science. Open minds, free debate, and objective data offer the best way forward.

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