

The Problem

British Columbia's rural and remote communities face a stark reality: when a patient becomes critically ill or injured, the emergency transport system often cannot respond in time.

- Rural mortality in BC is significantly higher than in urban centres
- Physicians have no pathway to escalate care when BCEHS resources are unavailable or delayed
- There is no backup capacity — no alternative provider when the system cannot respond
- These failures have been documented for more than 20 years without systemic resolution

Brayden's Story

Brayden Robbins was an eleven-year-old BC resident who became critically ill in a rural community. His local emergency team did everything within their power. But when BCEHS transport was delayed, there was no alternative. There was no mechanism to escalate. There was no backup plan.

Brayden did not die because of a failure by his providers. He died because the system had no way to reach him in time.

His mother, Nikki Robbins, has led the campaign for Brayden's Law — determined that no other family should face the same preventable tragedy.

"No family should lose a loved one because they live too far from a city." — Nikki Robbins

What Brayden's Law Does

"Brayden's Law", proposed by his mother, targets amendments to BC's Emergency Health Services Act to address three structural failures in the current system.

1. Physician-Initiated Transport

Authorises BC physicians to directly initiate an urgent or emergency transport response when clinical urgency demands it — without being blocked — when delay poses a significant risk to life.

2. Nonprofit PHRM Providers

Enables the Minister of Health to license qualified non-profit organisations — such as Med Response BC — to operate as authorised Prehospital and Retrieval Medicine (PHRM) providers under defined clinical and governance parameters, working collaboratively alongside BCEHS.

3. Tiered Transport Pathways

Creates structured escalation pathways so there is always a timely option:

- Tier 1: Scheduled / routine transfers
- Tier 2: Urgent medical transfers
- Tier 3: Emergency response — escalation to all available authorised providers for life, limb, or organ-threatening emergencies

Governance & accountability

- Coordination with the Patient Transfer Network and Emergency Coordination Centres
- Annual public reporting on transport times, outcomes, and patient experience
- Independent review body for adverse events
- Mandatory Indigenous partnership and cultural safety protocols
- Ministry-led evaluations at 3-year intervals

Why It Matters

BC is an outlier. Comparable jurisdictions have already modernised their emergency transport systems by integrating physician-led interprofessional retrieval teams — with measurable results:

- Norway (Norsk Luftambulans): rural-urban trauma mortality gap reduced to 1.4×
- New South Wales, Australia: gap reduced to 1.5×
- Wales (EMRTS Cymru) and Scotland (EMRS): integrated public-nonprofit retrieval models with proven survival outcomes

Research across Canada, Australia, the UK, and Europe consistently shows that physician-led PHRM teams save lives — particularly in trauma, sepsis, paediatric emergencies, and time-sensitive conditions.

Alignment with BC priorities

- BC Rural Health Strategy — operationalises the provincial rural lens in emergency health transport
- Declaration on the Rights of Indigenous Peoples Act — culturally safe, equitable emergency care
- Health system sustainability — reduces ER closures, provider burnout, and downstream costs

What MLAs can do

- › Champion "Brayden's Law" in the Legislature and with the Minister of Health
- › Meet with MRBC to discuss local emergency transport gaps in your riding
- › Raise the rural emergency care equity issue publicly
- › Advocate for the MRBC pilot project

Learn more & get involved

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