



Healthcare Access for People with Multiple Chemical Sensitivity in Canada

Lived Experiences, Systemic Barriers and Priorities for Action

Community consultation report | October 13, 2026, | EHAC–ASEC / ASEQ–EHAQ



Executive summary

On October 13, 2026, the Environmental Health Association of Canada and Environmental Health Association of Québec convened an online discussion about healthcare access for people with multiple chemical sensitivity (MCS). Following a short presentation, participants described barriers encountered in healthcare settings, examples of effective accommodations, and changes they considered important. The consultation was qualitative and voluntary; it does not represent a population-based survey.

The clearest message was that healthcare accessibility cannot depend on patients repeatedly negotiating exposure prevention with individual clinicians. Participants called for institution-wide responsibility encompassing product purchasing, maintenance, staff practices, accommodation procedures and ongoing monitoring. They also identified virtual care and positive experiences with accommodating providers as workable approaches.

1. Purpose and approach

The workshop, “Healthcare and MCS: Improving Patient Experiences,” invited patients and others to identify barriers, describe experiences and recommend improvements. The event included bilingual accessibility arrangements, a brief evidence-informed presentation and facilitated discussion. The themes below are an interpretive synthesis of the meeting transcript, not a count of how many participants endorsed each point. The automated transcript contains transcription errors; no direct quotations are reproduced here.

2. Findings from participant contributions

2.1 Environmental barriers across the care pathway

Participant input: Participants described concerns about fragranced products, air fresheners, floor-cleaning products, waiting areas and prolonged stays in hospitals. One participant distinguished tolerating a short visit from being able to remain in hospital for an extended admission.

Action indicated: Map potential exposure sources from arrival to discharge; review cleaning and maintenance products; establish advance planning for admissions.

2.2 Policies that are not consistently implemented

Participant input: Participants described healthcare settings where fragrance-free policies were not consistently implemented or monitored. One example involved a previously effective clinic policy that became less reliable after a knowledgeable clinician



left, highlighting the risks of depending on individual champions rather than institutional systems.

Action indicated: Establish permanent institutional procedures with clear leadership responsibility, staff education, appropriate purchasing and cleaning practices, regular monitoring, and mechanisms for corrective action and accountability.

2.3 Accommodation without repeated self-advocacy

Participant input: The discussion reflected frustration with having to explain access needs repeatedly and with unclear institutional responsibilities.

Action indicated: Create a clear request, documentation, response and escalation process, with patient consent and appropriate privacy safeguards.

2.4 Institutional leadership and procurement

Participant input: A participant argued that hospital administrators, facilities management, purchasing and occupational-health teams should be engaged alongside clinicians.

Action indicated: Identify accountable executives and operational leads; incorporate lower-emission choices and accessibility requirements into procurement and maintenance.

2.5 Education and respectful care

Participant input: Participants discussed the importance of staff understanding MCS, including the relationship between awareness, attitudes and willingness to accommodate.

Action indicated: Provide role-specific education for clinicians, reception, housekeeping, maintenance, purchasing and management.

2.6 Virtual care and alternatives

Participant input: Participants discussed telephone or video consultations as potentially valuable options where a clinical assessment does not require physical attendance.

Action indicated: Offer clinically appropriate remote appointments and alternative scheduling or waiting arrangements.

2.7 Effective accommodations are possible

Participant input: One participant described dentists who took concerns seriously and used air purifiers in treatment rooms. Another described a clinic where a policy had previously supported access.



Action indicated: Document successful practices and assess how they might be adapted in other settings.

2.8 Accountability and advocacy tools

Participant input: Participants discussed the difficulty of obtaining meaningful responses to complaints and the potential usefulness of templates for requesting accommodations.

Action indicated: Provide accessible request and follow-up templates, documented response timelines and transparent escalation routes.

2.9 Prevention and wider benefits

Participant input: Participants connected accessible indoor air with staff health, environmental management and the prevention of avoidable exposures.

Action indicated: Align patient accessibility work with occupational health, infection prevention and facilities planning, while preserving necessary clinical safety measures.

3. Cross-cutting observations

Access begins before the consultation and continues through treatment and discharge.

Policies without implementation and monitoring may fail to provide dependable access.

Individual clinical goodwill is valuable but cannot substitute for institution-wide procedures.

Patients need practical options and clear institutional points of contact, not repeated negotiation.

4. Proposed recommendations for consideration

1. Establish standardized healthcare accommodation procedures. Develop a model MCS-informed accommodation pathway that includes advance notification, a designated contact, documented follow-up, and accessible request and escalation procedures adapted to provincial and territorial requirements.
2. Implement and maintain environmental accessibility measures. Establish fragrance-free and lowest-emission source-control practices, including appropriate purchasing, cleaning and maintenance protocols, compatible with clinical and infection-control requirements.
3. Strengthen institutional leadership and accountability. Assign clear responsibilities across clinical operations, procurement, environmental services, facilities and accessibility. Establish regular monitoring, corrective action procedures and mechanisms for addressing accessibility concerns.



4. Provide education and training. Deliver role-specific training to clinical and nonclinical personnel on MCS, environmental accessibility, accommodation procedures and institutional responsibilities.
5. Expand accessible healthcare options. Preserve telephone and video consultations, flexible scheduling and alternative waiting arrangements when clinically appropriate.
6. Involve people with MCS in developing and evaluating solutions. Co-design practical guidance, accommodation procedures and institutional accessibility measures with people with MCS, and evaluate their effectiveness in healthcare settings.

5. Implications for a potential Centre of Excellence

The consultation suggests that a Centre of Excellence could serve not only as a specialized clinical resource but also as a national source of practical guidance for healthcare institutions. Potential functions include clinical pathways and referrals; model accommodation procedures; professional education; applied research and evaluation; and knowledge mobilization across jurisdictions. The Centre could also help healthcare institutions implement, monitor and sustain environmental accessibility measures, ensuring that progress does not depend on individual staff members. These are proposed interpretations of the consultation, not a formally endorsed participant mandate.

6. Evidence and interpretation

The workshop presentation referred to published research on healthcare access for adults with MCS, Canadian human-rights accommodation principles, professional policy developments and comparative indoor-air-quality research. These sources provide background; the participant findings in this report are based on the consultation discussion and should not be described as independent verification of all reported experiences.

The comparative building research discussed during the presentation found reductions of up to approximately 70% for certain measured hazardous volatile organic compounds in fragrance-free settings. The study did not directly test patient outcomes in hospitals; it supports consideration of source control, not a claim that all healthcare exposures would fall by the same percentage.

7. Next steps

Invite participant feedback on the anonymized themes where feasible.

Prepare a short policy briefing for discussions concerning a potential Centre of Excellence.



Use the recommendations to inform institutional engagement and future consultation.

Source materials: October 13, 2026, workshop; Healthcare and MCS bilingual slide deck; 15-minute speaker script.