

Fragrance and Chemical Sensitivity Support Group

Summary of

Response to the working draft report

A Scientific Review of Multiple Chemical Sensitivity: Identifying key research needs

As prepared by

National Industrial Chemicals Notification and Assessment
Scheme (NICNAS) and the Office of Chemical Safety

November 2008

NOTE

This document is an edited version of the full submission made. The full submission contains quoted scientific research and therefore is not able to be published on the NICNAS website.

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Edited version of submission to MCS Review

Page 1 of 18
3 May 2009

Summary and Recommendations

The FCSSG has several concerns with the process and content of this report.

- We are concerned with the fact that such a small sample of the medical community was consulted, and those that did participate admit they have limited experience. Further many participants had a vested interest in there being a psychological cause as they are funded by industry that is the very cause of this illness. Consequently their objectivity is in question. The positive aspect to this however is that there is a clear indication that further education and understanding of this illness needs to occur in Australia.
- Strong emphasis has been placed on odour and the onset of symptoms occurring only in that way. This is not the case. There are many chemicals used in industry and the food chain which also cause symptoms but can remain undetected by smell. For example it has been proven that preservatives, such as those used in bread, cause ADHD symptoms in children. This is a chemical sensitivity. MSG and how it affects people is another chemical sensitivity. More importantly odour does not cause respiratory problems.
- The strong emphasis placed on the cause being psychiatric is concerning given we know that so many healthy, happy people have been affected and that there has been a great deal of published data providing evidence that there are physiological affects occurring to the body from exposure to chemicals in our environment.
- While further research needs to be undertaken to understand the processes of chemical sensitivity we do not have time to wait for this to occur. We need action from the relevant government departments **now**. There is evidence that something is happening to make people ill after contact with chemicals. Just because the process is not understood should not mean delay in the establishment of protocols, policies and health management services.
- The findings and recommendations of this report should included notification to other relevant government departments that there is a problem and suggest that investigation be undertaken as to how those who are ill can be helped.

- Other countries, more recently Germany (2008), have recognized chemical sensitivity as a physical disorder. It is past time that Australia did the same. There is enough research published proving that it is a real physical disorder.
- Australia needs to use the resources already available: namely published research showing a link between chemicals and ill health, the experience of worldwide established clinics, organisations who assist, monitor and investigate those who are ill.
- The impact of the working draft has already been felt with it being quoted in The Cleveland Daily Banner on 4 January 2009. Specifically they have quoted the Australian report : *According to the report, since the cause is unknown and the symptoms vary between individuals, the term Idiopathic Environmental Intolerance or IEI is favored by the World Health Organization "because it does not make inferences with regards to causative agents. This reflects the lack of an agreed biological basis for MCS symptoms."*
WHO issued a statement in 1996 saying: with respect to 'MCS,' WHO has neither adopted nor endorsed a policy or scientific opinion" WHO has never proclaimed to favour the term Idiopathic Environmental Intolerance. The statement that they have needs to be removed.

This report needs to be extremely accurate. The world is watching us, we need to get it right and we need to do it well. The statement regarding WHO needs to be removed.

- To continually perpetuate the concept that normal happy, healthy people suddenly decide chemicals are affecting them, that they have a psychological disorder is not only incompetent and unformed, but negligent. Stress can exacerbate the sensitivity but any psychiatric problems come after, not before the onset of chemical sensitivity.
- The Australian Government needs to look after the interest of the citizens of this country and not protect industry as they are now doing.

Response Note 1: Para 1.1 (Overview) and Para 1.2.2 (Clinical research needs), page 7 and 9

NICNAS / OCS Review

*“some challenge tests suggest that it is the smell or odour of a triggering agent, rather (*than*) any of its pharmacological or toxicological properties per se that elicit MCS symptoms.”*

FCSSG Response

It is not a smell or odour that is the trigger. I have personally participated in a “blinded” test and reacted to the chemical. A smell or odour can not induce respiratory symptoms such as asthma. An asthmatic wheeze caused by irritation to the respiratory airways is not induced willingly. A smell or odour cannot induce ADHD like symptoms or other affects on the Central Nervous System. As an example MSG causes respiratory problems, asthma and hyperactivity. It has no odour and the manner of exposure is ingestion.

Response Note 2: Para 1.2.1 (Research into the cause(s) of MCS), Page 8

NICNAS / OCS Review

“...also a psychological or psychogenic component in its pathogenesis.”

FCSSG Response

There is a psychological component to Chemical Sensitivity but it comes after the cause, it is not the cause of Chemical Sensitivity. Exacerbation of the illness occurs where stress is involved due to the political (not government), legal, workplace intolerance issues that come with the illness. The body being constantly bombarded with a chemical also causes stress on the body systems functioning. Dr Kaye Kilburn has done extensive work showing that chemicals are impairing brain function and considers that the functional loss resembles accelerated ageing.

The affect of stress and altered levels of cortisol has been discussed in the book *Explain Pain*, by David Butler and Lorimer Moseley. Consistent pain causes neurones to become over sensitive. The brain concludes there is a threat and sensitization of the bodies alarm system occurs with the brain wrongly being told the body is in danger. Chemicals are also sensitizers and the same process occurs. The brain is learning a wrong message.

Response Note 3: Para 2.1 (What is Multiple Chemical Sensitivity), Page 10

NICNAS / OCS Review

“... the descriptor Idiopathic Environmental Intolerance or IEI is favoured by many ... “

FCSSG Response

The term Idiopathic Environmental Intolerance is an unacceptable term, as are many of the others listed. Idiopathic implies that there is no known cause. There is a known cause. It is complex, it is a puzzle with many pieces, many body systems involved.

WHO has never proclaimed to favour the term Idiopathic Environmental Intolerance. The statement regarding WHO needs to be removed.

The FCSSG supports the term Chemical Sensitivity. It is chemicals in the environment and our food (processed and food chain) that is causing the illness.

The FCSSG supports the MCS definition of 1999. The criteria are accurate in describing the process which occurs.

Response Note 4: Para 2.1 (What Is Multiple Chemical Sensitivity), Page 10

NICNAS / OCS Review

“ ... the search for single causative mechanisms and single treatment regimes will not be fruitful if there are a number of conditions existing under the general label of MCS.”

FCSSG Response

The Medical and scientific community likes to pigeon hole causes of illnesses before they accept it is real.

I don't believe they ever will “pigeon hole” chemical sensitivity and chronic fatigue. There are too many variables on how the onset of symptoms occurs. There is not one causative mechanism. There are many physiological processes involved which is why there are so many symptoms. Not every person experiences all the symptoms. This review and the scientific and medical community will progress much better in their understanding of the disorder if they accept this fact.

It is appropriate that there is an overlap between the likes of Chronic Fatigue Syndrome and Chemical Sensitivity as many symptoms are shared and indeed CFS can be considered a symptom of Chemical Sensitivity as the onset of CFS can occur after a chemical injury.

Do not get bogged down in trying to avoid linking CFS and Fibromyalgia etc with Chemical Sensitivity. The common cold and Influenza share many symptoms but both are considered separate illnesses. Not everything is black and white, there are many grey areas in everything.

Response Note 5: Para 2.3 (Is MCS related to other syndromes or disorders?), Page 10

NICNAS / OCS Review

"It has been suggested by others that many cases of these disorders seem to be triggered by short-term stressors, most commonly infection for CFS, physical trauma for FM, severe psychological stress in PTSD and exposure to some environmental agents in MCS (Pall, 2003)."

FCSSG Response

Infection such as the Epstein Barr virus is not the only cause for Chronic Fatigue. Other causes are stress and the brains reaction to inflammation and / or injury, a triggered response when the body requires rest to regenerate.

Clearly Pall supports the concept that chemical sensitivity is caused by an environmental agent.

Dr Kaye H. Kilburn has done extensive research and seen many patients, his findings support the theory that chemicals are affecting the brain and that chemical sensitivity is an organic illness. In his book *Chemical Brain Injury* he writes of how the brain and central nervous system are targets for chemicals. He finds that multiple health complaints arise from the brain, in most cases.

Response Note 6: Para 2.3 (Is MCS related to other symptoms or disorders?), Page 12

NICNAS / OCS Review

"The cause of SBS is unknown, but it is often thought to result from poor building ventilation causing a build-up of vapours from sources that include building materials, furnishings and office equipment"

Author: Fragrance and Chemical Sensitivity Support Group

Edited version of submission to MCS Review

Page 6 of 18

3 May 2009

FCSSG Response

The cause of SBS is known and widely accepted, it has been proven that VOC's build up in poorly ventilated offices. It is so widely accepted that many governments are now requiring buildings be designed in a manner that prohibits SBS and that they use construction material with lower emission levels.

Response Note 7: Para 2.5 (Can MCS be clinically defined), page 13

NICNAS / OCS Review

"... objective measures or physical findings do not exist to permit confirmation of any organic dysfunction and that the disorder is patient defined ..."

FCSSG Response

The patient reports a range of symptoms they are experiencing to their medical practitioner. The patient is not defining the illness they merely report the symptoms.

There has been protocol published for diagnosing chemical sensitivities: DEFINING CHEMICAL INJURY: A Diagnostic Protocol and Profile of Chemically Injured Civilians, Industrial Workers and Gulf War Veterans, G. Heuser, M.D., Ph.D., P. Axelrod, and S. Heuser, M.A.

The protocol is a logical approach with a wide range of tests, through all body systems, to rule out any other possible diagnosis. Such tests have determined that there is organic dysfunction occurring.

Research has shown extensive physical findings but due to the fact that the condition is so poorly understood, and that tests are cost prohibitive, the majority of chemically sensitive people have not had the physical symptoms proven.

Dr Kaye Kilburn discusses performance measures in his book, *Chemical Brain Injury*. Balance, reaction time, vision, hearing, odour perception can be measured.

Response Note 8: Para 2.5 (Can MCS be clinically defined), Page 13

NICNAS / OCS Review

"A World Health Organisation workshop on MCS held in 1996 described the condition as an acquired disorder with multiple recurrent symptoms, associated with diverse environmental factors that are tolerated by the majority of people and that is not explained by any known medical or

Author: Fragrance and Chemical Sensitivity Support Group

Edited version of submission to MCS Review

Page 7 of 18

3 May 2009

psychiatric/psychological disorder. The workshop also concluded that use of the term MCS should be discontinued because it makes an unsupported judgement on causation noting the existence of several definitions of what has been caused MCS. The workshop favoured the descriptor “Idiopathic Environmental Intolerances” (IPCS, 1996).”

FCSSG Response

There was, and is, evidence to show that chemicals are causing illness. The findings of this workshop are outdated considering what is known about how chemicals are affecting health. As discussed earlier the WHO did not approve the term Idiopathic Environmental Intolerance.

Response Note 9: Para 2.6 (Does MCS have a disease classification), pages 16, 17

NICNAS / OCS Review

“ ... the proposal for a unique code in ICD-10-AM for MCS was rejected on the following basis (J Rust, NCCH, Personal Communication, 2004):

There is no clinical or laboratory evidence of an underlying pathological process in patients who have acquired this descriptive label, despite many attempts to identify one over the past 20 years;

There is a wide spectrum of intolerance/irritation from smells and fumes in the general population and it is not possible to draw any clear dividing line to delineate patients who might fall into the category of the proposed classification;

There are no internationally accepted diagnostic criteria, nor validated diagnostic tests;

There are a number of syndromes (i.e. symptom complexes) that appear to overlap with the clinical features proposed for the category of MCS such as CFS and FM. The relationship between these entities and MCS syndrome is unclear at present and this creates difficulty with diagnostic categorisation.”

FCSSG Response

The mere fact that the scientific community cannot come up with one specific test to test all the body's systems involved in this disorder, and that described symptoms overlap other defined disorders, should not stop any disorder from being accepted as a real illness and subsequently coded and indexed.

Influenza and the common cold share some common symptoms, yet both are accepted as individual disorders. There are many other widely accepted disorders that share symptoms.

Response Note 10: Para 3.1.3 (Limbic kindling,/ neural sensitisation), page 23

NICNAS / OCS Review

“With regard to levels of exposure necessary for kindling to occur, chemical kindling or time-dependent sensitisation in animals typically occurs in response to pharmacologically effective doses of chemicals rather than at the low doses alleged to cause MCS in humans. This suggests that if limbic kindling was part of the aetiology of MCS, a higher prevalence of MCS would be expected in individuals with higher levels of chemical exposure, such as those exposed to chemicals in industrial settings, which is not the case (Labrage & McCaffrey, 2000).”

FCSSG Response

Low levels of exposure are not causing Chemical Sensitivity. However, continuous, low levels, accumulating over a period of time are. Many chemicals are known to be sensitisers.

Response Note 11: Para 3.1.6 (Behavioural conditioning), Page 25

NICNAS / OCS Review

“In experimental trials of conditioned reactions in healthy subjects, Van den Bergh et al (1999) demonstrated that subjects can acquire and then lose somatic symptoms and altered respiratory behaviours in response to harmless, but odorous chemical substances, if these odours were associated with an unrelated symptom-inducing physiological challenge (hyperventilation from exposure to CO2 enriched air). The conditioned responses were modest but reproducible and support the view of MCS at least in part as a behavioural conditioning. Subsequently, through stimulus generalisation, other odorous agents may begin to elicit the conditioned response or even the perception of exposure (Bolla-Wilson et al., 1988; Devriese et al, 2000; Lehrer, 2000).”

FCSSG Response

If one chose to, you could also conclude that there was a physiological reaction to this challenge which did not have a long term affect on the healthy subjects. As usual scientific findings are open to interpretation, depending on the answer you seek and want to prove.

The question needs to be asked how does Van den Burgh know the chemical substances were harmless. The majority of chemicals have not been tested for safety.

The brain has been proven to learn responses, adapt and to over react to stimuli.

Response Note 12: Para 3.1.7 (Psychiatric disorders),
page 24

NICNAS / OCS Review

“Hypothesis: Psychiatric factors have variously been seen as the cause of MCS, an effect of having MCS, a predisposing factor in the development of MCS, and a co-morbid occurrence with MCS.”

FCSSG Response

The psychiatric symptoms occur after the exposure. There is a proven link between chemical sensitivity and disorder of the central nervous, respiratory systems.

Those who have chemical sensitivities do not want to have it. They want the health they had before the onset of symptoms.

There has been a great deal of published research which shows physiological occurrences after exposure to chemicals.

Dr Kaye Kilburn in his book, *Chemical Brain Injury*, writes about neuro behavioural dysfunction being caused by chemicals found in the environment. He also states that chemical brain injury is misdiagnosed with the symptoms often being attributed to old age and stress, among other labels.

Response Note 13: Para 3.1.7 (Psychiatric disorders),
page 26

NICNAS / OCS Review

“In challenge studies using known triggers of panic attacks (intravenous sodium lactate or carbon dioxide), between 71-100% of MCS patients were reported to experience panic attacks compared to 26% of controls (Simon et al. 1993; Binkley & Kurcher, 1997)”

FCSSG Response

Of course already chemically sensitive people are going to react more than the control group under this sort of test situation, their systems are already on overload. Over a long period of time, lengthy illness, many people become fearful, quite naturally and without consciously thinking of it, of any smell. The brain has learned a response.

Response Note 14: Para 3.1.7 (Psychiatric disorders),
page 27

NICNAS / OCS Review

*“ ... anxiety might be an important baseline factor for the acquisition of MCS
... ”*

FCSSG Response

We accept that anxiety and stress is a factor in exacerbating chemical sensitivity, it does not cause the sensitivity.

Response Note 15: Para 3.1.7 (Psychiatric disorders), page 27

NICNAS / OCS Review

“... an important question is the extent to which this is the cause or an effect of an individual’s MCS condition. Davidoff et al. (2000) documented similarities between the psychopathological profiles of MCS sufferers and psychopathological profile changes, predicted by professionals that would likely occur in normal individuals as a result of MCS or a similar chronic condition. They concluded that inferences of mental ill health in chronically sick people may be inevitable and inappropriate with “one shot” psychological profiling and that distinguishing preexisting psychopathology and psychopathology secondary to organic disease in MCS with such profiling may be misleading.”

FCSSG Response

We reiterate our position that the illness has a psychiatric component, but that this occurs after the onset of organic symptoms. We firmly believe that a psychiatric diagnosis is being made in the absence of experience and understanding of chemical sensitivity by the medical community. Those suffering from Multiple Sclerosis were once told they were depressed before the condition became better understood.

Response Note 16: Para 3.1.8 (MCS as a ‘belief system’), page 27

NICNAS / OCS Review

“Sparks (2000b) suggests that MCS is a phenomenon best described as a ‘belief system’ characterised by an overvalued idea of environmental hazards and their debilitating effects, pointing to evidence illustrating that individual belief systems can be manipulated or conditioned to respond to innocuous, yet odorous triggers that can cause pathophysiology associated with MCS. Behavioural approaches to MCS therefore should aim towards symptom desensitisation and the prevention of reinforcement of illness behaviour”

FCSSG Response

See response note 17

Response Note 17: Para 3.1.8 (MCS as a 'belief system'), page 27

NICNAS / OCS Review

"Physiological processes such as exposures to odours under distressing circumstances may interact with beliefs, perhaps engendered by media reporting, reinforcing the interpretation of somatic sensations as pathological."

FCSSG Response

It is not only chemicals with an odour that cause symptoms. The perfect example is the inducement of asthma after consuming MSG. Typically a person who is experiencing ill health goes to their general practitioner. Tells the GP of their symptoms and expects assistance in discovering why they are feeling unwell. A GP should then be taking a history, running tests, to assist in making a diagnosis.

An ill person, excluding hypochondriacs, does not present to a GP at the onset of symptoms, labelling themselves as I have chemical sensitivity.

It is only after no answers are forthcoming from the GP or specialist allergist that they seek out their own answers.

Normal, healthy, active people have had their lives drastically changed as a result of becoming sensitive to chemicals.

A degree of desensitisation can occur if the chemical incitant is not encountered, but this takes a long time, and in indeed some will never be completely well.

Response Note 18 and 19: Para 3.1.9 (Odour perception), page 28

NICNAS / OCS Review

"Healthy subjects can also experience either 'adaptation' or 'sensitisation' to odours, depending on whether subjects are led to believe the odour was natural and healthy, or potentially hazardous (Dalton & Hummel, 2000)."

"... concluded that MCS subjects do react to chemical challenges, but that these responses occur when discernment is possible between active and sham substances, suggesting that the mechanism of action is not chemical-specific, but related to expectations."

FCSSG Response

It is not only chemicals with an odour that are causing chemical sensitivity.

The very purpose and nature of fragrance inspires in us a feeling of well being, something pleasant. We like smells. Chemical Sensitivity sufferers could not adapt or become sensitised to believe a

fragrance was harmful unless harm had come to them from fragrance. We did not consider them hazardous until after experiencing physiological symptoms.

Response Note 20: Para 3.1.10.3 (Other proposed mechanisms, page 28

NICNAS / OCS Review

“In MCS cases, serum chloroform levels were higher and ethylbenzene, xylene, 3-methylpentane and hexane levels were lower.”

FCSSG Response

The FCSSG finds this most interesting. Given that we have high levels of chlorine in our water and that chlorine when heated turns to chloroform, is it possible that chloroform, a sedative is causing the fatigue symptoms experienced by so many?

Response Note 21: Para 3.2 (Commentary on the proposed models of action), page 30

NICNAS / OCS Review

“The currently available toxicological information does not support the view that MCS arises solely from the toxic effects of low-level exposure to chemicals in the environment. Specifically, it does not explain the diverse symptoms affecting multiple organ systems or the diverse range of triggering agents. Furthermore, it cannot be explained why the same chemical trigger can induce different symptoms in different MCS patients. No currently known biological mechanisms, processes or anatomical alterations can adequately explain such divergent effects (Gots & Pirages, 1999).”

FCSSG Response

Whether or not the dose can considered toxic is immaterial, it has been proven that low levels over a long period of time can be harmful.

Do we all get cancer, do we all get MS, do we all get diabetes, do we all get the flu? No we do not. Therefore it is unreasonable to expect that all chemically sensitive people will experience the same symptoms and that all people will become sensitive to chemicals. Each person’s individual physiological makeup affects how the body system reacts.

Response Note 23: Para 3.2 (Commentary on the proposed models of mode of action) page 31

NICNAS / OCS Review

“Another argument in support of a physiological basis for MCS is that in the absence of an identifiable acute exposure associated with the sensitisation event in MCS, the disorder might be caused by cumulative effects from low-level exposures, resulting in an exceedence of a body-load tolerance threshold. While there are examples of harmful effects from long-term cumulative exposures to low-levels of certain toxins (e.g. metals), this scenario differs from that proposed for MCS, as the toxin can be quantified in the body and its presentation follows a well-defined toxicological paradigm. In contrast, no evidence of accumulation of toxic chemicals in MCS subjects has been found.”

FCSSG Response

We believe that there is a cumulative effect of chemicals causing sensitivity. There is evidence that the body, particularly the brain, is being harmed by chemicals. Neurological tests have proven this. The fact that there is no evidence of toxic chemical in Chemical Sensitivity subjects is indicative of the fact that many chemicals have not been tested, that the cost of tests to the ill person is prohibitive, that there are thousands of chemicals in use, so how do you test for them?

Having said this however studies have shown that chemicals have accumulated in mammalian bodies.

Response Note 24: Para 3.3 (Further research to identify potential causative mechanisms of MCS), page 32

NICNAS / OCS Review

“The most credible physiological mechanism for MCS is limbic kindling/neural sensitisation which proposes that sensitisation of the olfactory, limbic, mesolimbic and related pathways of the central nervous system occurs as a result of, or in the context of, chemical exposure. The scientific weight-of-evidence currently suggests that while physiological mechanisms may play a part in MCS, there is also a psychological or psychogenic component in its pathogenesis.”

FCSSG Response

The onset of psychological disorders occurs after the onset of chemical sensitivity.

The weight of evidence that suggests that there is a psychological pathogenesis is outweighed by the evidence there is a physiological pathogenesis.

Response Note 25: Para 4.4 MCS Clinical Management Principles, Page 40 and Para 5.4.3 (Principles For The Management of MCS), page 49

NICNAS / OCS Review

Principles for the management of MCS

FCSSG Response

Throughout these principles words are used which indicate the contributing clinicians do not believe this is a physiological disorder. While a supportive medical practitioner and a positive attitude are highly important in health care and management we must again reiterate that there is a great deal of evidence supporting the fact that this is a physiological disorder which has psychological symptoms after the onset of the physiological.

Response Note 26: Para 4.5 (Clinical research needs), Page 40

NICNAS / OCS Review

“Challenge tests suggest that it is the smell or odour of a triggering agent, rather any of its pharmacological or toxicological properties per se that elicit MCS”

FCSSG Response

A chemical does not have to have an odour for symptoms to be triggered eg: MSG

Response Note 27: Para 5.1 (The Survey Process), page 42

NICNAS / OCS Review

“Phase 2 consisted of a one-day workshop involving clinicians and/or experts from a range of general practice and specialist medical backgrounds who had been identified as having experience in dealing with people with symptoms associated with chemical sensitivity.”

FCSSG Response

Refer to response note 29.

Response Note 28: Para 5.1.1 (Stakeholder contact), page 41

NICNAS / OCS Review

Author: Fragrance and Chemical Sensitivity Support Group

Edited version of submission to MCS Review

Page 15 of 18

3 May 2009

“Table 3. Summary of responses from key professional organisations”

FCSSG Response

Refer to response note 29.

Response Note 29: Para 5.1.3 (Interviews), page 45 and Para 5.3 (The common ground), Page 46

NICNAS / OCS Review

“Interviews were completed with:

4 general practitioners (GPs);

2 immunologists;

1 allergist;

2 occupational physicians;

2 respiratory physicians;

2 psychiatrists;

1 ear, nose and throat (ENT) surgeon;

1 toxicologist;

representatives from 4 MCS support and advocacy groups;

3 people suffering from MCS.”

“Responses to questionnaires demonstrated that individual clinical views were polarised, vigorously stated and defended, based mainly on individual belief and limited clinical experience.”

FCSSG Response

Interesting, but not surprising, that the AMA, the RACGP had no official position. More particular worthy to note that the APS did not have a position either. Psychological evidence is so often used throughout this report, yet the APA has no position.

As you have stated in your report there is a clear requirement for further research and education.

Interviews were completed with a very small sample of the scientific and medical community and while understanding the difficulties in finding qualified and knowledgeable medical practitioners, we find it concerning that practitioners with limited clinical experience have been involved and that such emphasis has been placed on their views when the weight of evidence clearly shows that people are sick from chemical exposure in their day to day lives.

Response Note 30: Para 5.3 (The Common Ground), page 46

NICNAS / OCS Review

Author: Fragrance and Chemical Sensitivity Support Group

Edited version of submission to MCS Review

Page 16 of 18

3 May 2009

“On the other side of the debate, some clinicians, respected overseas medical organisations and at least one local clinical organisation stated strongly that MCS is neither a diagnosis nor a syndrome but a range of sometimes disparate disabilities with some common presenting symptoms. Some described the presentations as a somatoform disorder, with symptoms in the absence of an identifiable general medical condition. These clinicians consider that psychological conflicts become translated into physical problems or complaints.”

FCSSG Response

The term Chemical Sensitivity accurately describes what is occurring. The brain and body becomes sensitised to chemicals. It is an organic medical condition with a broad base of symptoms across most if not all body systems.

Response Note 31: Para 5.3 (The Common Ground), page 47

NICNAS / OCS Review

“Other clinicians considered MCS to be a psychopathological condition created, enhanced, and perpetuated by the law and its application, termed a “nomogenic” disorder. They argue that some doctors and lawyers have provided patients presenting with a range of symptoms, some of which may be related and all of which become attributed to a sensitivity to chemical odours, with the identifying label, “MCS”. These clinicians consider that patients presenting with such problems are more often likely to have been exposed to chemicals in the course of their work and may be seeking something or someone to be responsible for their ill health and/or to achieve compensation from an employer or some other source to make recompense for the disability.”

FCSSG Response

Clearly this statement is based on ignorant, uninformed opinion of insurance company doctors who sell themselves for the dollar, with no interest in the truth.

People who are sick go to their doctor with symptoms expecting a diagnosis, a treatment, and to subsequently get well.

They are not deciding oh I am going to go out and say I have MCS I am going to take legal action and then find a doctor to support that. All employers and manufacturers have a duty of care to provide safe environments to work in and products that are safe for use and consumption.

It is clearly appropriate and lawful that if this duty of care has not been met seeking compensation is a valid action on the part of the injured person whose quality of life is so drastically changed.

Response Note 32: Para 6.2.8 (MCS in the US Courts),
page 53

NICNAS / OCS Review

“In the USA, legal activity and consequences surrounding MCS has been noted to outpace the science (Gots 1995). Some courts have recognised MCS as a compensable disease whereas others disregard causation and award benefits to the plaintiff considered disabled by a somatisation disorder or psychological impairment. This is despite the equivocal scientific evidence that MCS is an organic disease (Barrett, 2000a).”

FCSSG Response

We totally agree with this statement. The legal system, and more importantly the medical system, has not kept pace with what is happening to people. That courts are awarding purely on a psychological cause is negligent, and shameful, when there is clear evidence linking the onset of symptoms with chemical exposure. However most recently a precedent has been set by a US District Judge

Response Note 33: Para 6.3 (Canadian Government),
Page 54

NICNAS / OCS Review

Entire paragraph talks about the Canadian Governments response to chemical sensitivity.

FCSSG Response

No mention is made of the fact that the Canadian Human Rights Commission has developed a policy with regards to chemical sensitivity, the commission recognises it as a medical condition and a disability.

The Halifax Regional Municipality, Nova Scotia has instigated a public awareness program which has been very successful.