Being a Christian in the UK today – an Inquiry by Christians in Parliament

Response from Christian Medical Fellowship

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 5,000 British doctor and nurse members in all branches of medicine, nursing and midwifery and around 800 medical and nursing student members. We are the UK's largest faith-based group of health professionals. A registered charity, we are linked to about 80 similar national bodies in other countries throughout the world.

Question 1: In what ways do Christians make a positive contribution to UK society? Please provide specific details/examples from your experience.

The Christian faith emphasises the values of compassion and service that make caring professions natural career choices for many Christians. The Christian faith has had a profound influence in shaping healthcare in Britain and many famous NHS hospitals and medical schools began life as Christian institutions. The pioneers of the hospice movement were motivated by their Christian faith. Christians continue to make a significant contribution in healthcare provision today.

By and large, Christians are able to function happily within a normal NHS work environment whilst still remaining faithful to their beliefs. However, some Christian convictions and practices call for additional awareness on the part of NHS employers and employees, particularly where freedom of speech or conscience are at issue.

Quotes from members:
(Psychiatrist): '*Christians are over-represented amongst the caring professions and charities and their faith is a major reason why they do what they do.'*

'Churches and faith groups continue to provide amazing levels of input to supplement the NHS locally - all the way from counselling services to homeless shelters.

Christian healthcare professionals are often very holistic in their outlook and may make referrals to a food bank (Trussell Trust)[1], debt counselling (Christians Against Poverty - CAP[2]), mental health care services, local projects to support the elderly or housebound, community pastoral carers such as Parish Nurses (community pastoral care and health promotion in over 100 churches in local communities).[3]

Health in the sense of wholeness is understood by Christians to embrace a **spiritual dimension.**

Quotes from members:
(**Student**): *Even as a student I have already had many encounters with older patients whose outlook on illness and their future is often more Christian. Here I have been able to empathise and understand the patient very deeply, leading to satisfaction for both parties.*

(**GP**): '*My feedback about being a Christian GP is that I come face to face with spiritual need on a daily basis.*' *But I don't feel free to talk to my patients about Jesus because of cases of Christians being disciplined for sharing their faith with patients.*

(**Consultant**): '*a number of Christians I see around me, are seen as beacons of integrity, gentleness, caring and bringing people together. They keep teams going, keep themselves going when things are tough, and are seen as role models to others. There are the occasional exceptions, like any human being, but by and large the influence from a really small minority now, is significant.*'….' For example:

[1] https://www.trusselltrust.org/
[2] https://capuk.org/
[3] https://parishnursing.org.uk/

'*kindness to others, when others are beginning to relapse into cynicism and a slough of despond…compassion not just to patients but also carers and staff.*
Serving others: we don't tend to question this, we just do it – it is part of our DNA. Many of us have given our lives to work in the NHS, often to help the poor and marginalised. We recognise that this is no different to many non-Christians, and the motivation remains love for others. The difference is that we recognise love as having its source in a holy, compassionate, self-giving God. Jesus had an eye out for the vulnerable and 'weak' in society – many of us Christian healthcare practitioners will stand up for and safeguard those most vulnerable, simply because that is what we're driven to do.'

Question 2: In what ways do public institutions (such as local and national government, the legal system or regulatory bodies) support Christians engaging in public life?

The following laws and guidance help everyone (not just Christians) in a limited but useful way:

Statutory conscience protection in the HFE Act for activities authorised by that Act.[4] At CMF we have not been contacted by any members who have faced discrimination or coercion in the activities authorised by the HFE Act.

The Abortion Act 1967 offers protection from direct involvement only.[5]

The General Medical Council (GMC), the official regulatory body for doctors, Guidance 2013 '*Personal Beliefs and Medical Practice*' permits some sharing faith, and allows conscientious objection to abortion, contraception and gender reassignment but this is limited to doctors.[6]

General Pharmaceutical Council (GPhC) Guidance allows referral in case of conscientious objection.[7]

The Equality Act and ECHR guarantee freedom of thought, conscience and religion.[8]

Question 3: Are there barriers to Christians engaging in public life? Please provide examples relevant to your knowledge and experience.

For Christian doctors the main impact has been felt in the areas of sharing Christian faith (evangelism), expressing beliefs about Christian ethics or manifesting Christian behaviour especially in the areas of prayer and/or sexual and life ethics.

1.Sharing faith

Freedom to speak to patients about matters of faith, and to share their personal stories, as appropriate, will be valued and respected by Christian healthcare workers and should be permitted on grounds of freedom of expression.

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[4] *No person who has a conscientious objection to **participating in any activity** governed by this Act shall be under any duty, however arising, to do so.* The Human and Fertilisation and Embryology Act (1990)

[5] *No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to **participate in any treatment** authorised by this Act to which he has a conscientious objection Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.* http://www.legislation.gov.uk/ukpga/1967/87/section/4

[6] '*You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients.*' '*You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.*' https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

[7] Right to refer: *Pharmacy professionals should use their professional judgement to decide **whether a referral is appropriate** in each individual situation.*

[8] Article 9 guarantees 'the right to freedom of thought, conscience and religion.'

GMC guidelines approve discussion of faith issues with patients provided it is done appropriately and sensitively. Doctors can talk about their personal beliefs if a patient asks but they must not impose beliefs or values on patients. The guidance generally gives some latitude to doctors attempting to provide whole-person healthcare (including spiritual care) but takes a harder line on doctors who attempt to share their own faith with patients in the context of a consultation.[9]

Quote from member:
(GP): *I come face to face with spiritual need on a daily basis…but I don't feel free to talk to my patients about Jesus because of cases of Christians being disciplined for sharing their faith. I question my future in the NHS because of the lack of freedom to be open about the healing saving love of Jesus. In the meantime, I continue to strive to love my patients in a practical way*.'

Note that most of our members do not hold this concern and CMF runs a popular course called Saline Solution which equips Christian healthcare workers to live their faith out in the work place, and to learn how the spiritual dimension of the patient affects them.[10]

2. Conscience

In our experience, the pressure points in the UK where healthcare professionals are facing the most serious conscience discrimination are with abortion, emergency contraception prescribing and gender reassignment.

Abortion:
Those that are most at risk of being discriminated against in our experience are GPs, junior doctors, nurses, midwives and pharmacists who are involved not directly in carrying out the abortion but in the pathway of preparation for it.

It is important to understand that anyone who objects to the act of abortion, or embryo research/gamete donation will see any involvement in the entire process as signalling a degree of complicity.

For example, for abortion, signing an authorisation form, clerking a patient for anaesthetic, providing preoperative care, prescribing or referring to another healthcare professional who does any of these things also involves complicity and must also be covered by the freedom of conscience provision. Also, several tasks that amount to arranging abortion, including taking telephone calls to arrange medical terminations of pregnancy managing resources, and allocating staff to patients.

The situation is getting harder for nurses and midwives. Many ante-natal and post-natal wards are being used for terminations, not least because of the pressure on Obs & Gynae beds (although the pressure on ante and post-natal wards is hardly any less at present, and probably even greater), so it is possible that more and more midwives will be involved in caring for women undergoing abortions. (Please note, these concerns do not apply to treatment or care in an emergency).

At the same time, protection for nurses and midwives has weakened. In 2016 the Royal College of Midwives (RCM) issued a position statement that midwives should be involved in all care of a woman undergoing an abortion.[11] They have the right to opt out on the basis of conscience, only from clinical procedures that are directly involved in the abortion. This further hardens clause 4.4 of the NMC Code that likewise allows for conscientious objection in very limited circumstances. It is not built on any Parliamentary ruling but on the 2014 Doogan and Wood case which centred on what constituted actually being involved in an abortion procedure. [12] The Supreme Court ruled that two senior midwives had no right to opt out of supervision,

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[9] GMC includes the need to take account of '*spiritual, religious, social and cultural factors'* in 'assessing a patient's conditions and taking a history. '*You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.'* https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

[10] https://www.cmf.org.uk/resources/media/?context=entity&id=41cf43f1c4bc4f4277adb42896f5c3ed3c7c523b

[11] https://www.rcm.org.uk/sites/default/files/RCM%20Abortion%20Statement.pdf

[12] **4.4** [you must] inform and explain to colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that

delegation or support of junior staff involved in abortions, as the right to conscientious objection only applied to those involved in direct, clinical procedures ie doctors doing abortion operation or inserting pessaries. It thus leaves those not directly involved in treatment no longer covered. The Court ruling was a drastic narrowing of the right to conscience, especially for midwives and nurses in managerial positions in the NHS.

'*The conscience clause does not cover making bookings or aftercare for patients who have undergone a termination. Nor does it cover fetching the drug before it is administered. "Participating" is limited to direct participation in the treatment involved. It does not cover administrative and managerial tasks.'* [13]

The Supreme Court also ruled that a GP who either refers or signs a certificate [to the effect that a woman satisfies the statutory grounds for abortion] is not involved in the 'treatment process' since treatment cannot commence until after such certification has taken place and so is not covered by section 4(1). So: '*The conscientious objector is under an obligation to refer the case to a professional who does not share that objection'.*

Currently GMC guidance does not insist on referral but states: 'Y*ou must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.'*[14]

Gender Reassignment

Sex is understood by Christians as male or female, a binary norm (though anomalous intersex conditions, caused by failure of sexual differentiation in the developing baby, do occur rarely). Christians recognise that some people suffer incongruence between their biological sex and their gender identity (gender dysphoria) but will favour responses that seek to re-align mind with body, not vice versa. They may therefore object to prescribing or dispensing puberty blocking agents or cross-gender hormones or to referring for gender reassignment procedures.

Gender reassignment - through hormones and/or surgery - is legal in this country but remains very controversial. Many doctors in this country, for a variety of reasons, do not wish to be part of providing this 'treatment', either through prescribing hormones, or acting as surgeons or as part of the referral pathway or pre-operative assessment.

The GMC recognises that these doctors do have a legal and ethical right not to be involved, while still offering the same standard of medical care to transgender patients as they do to any other patients.

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person's care. (Footnote to 4.4: 'Conscientious objection' to participating in a particular procedure can only be invoked in limited circumstances as follows:
Article 4(1) of the Abortion Act 1967 (Scotland, England and Wales)
This provision allows nurses and midwives to refuse to participate in the process of treatment which results in the termination of a pregnancy because they have a conscientious objection, except where it is necessary to save the life or prevent grave permanent injury to the physical or mental health of a pregnant woman.
Article 38 of the Human and Fertilisation and Embryology Act (1990)
This provision allows nurses and midwives the right to refuse to participate in technological procedures to achieve conception and pregnancy because they have a conscientious objection.
Significantly, the code references the Supreme Court decision in **Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland) [2014] UKSC 68** which provides additional information on the meaning of participation in any treatment.https://www.nmc.org.uk/standards/code/conscientious-objection-by-nurses-and-midwives/
https://www.nmc.org.uk/standards/code/?utm_source=Nursing+and+Midwifery+Council&utm_medium=email&utm_campaign=5502533_Nurses+and+midwives+25+March+2015&dm_i=129A,39XS5,6681LE,BQ3F5,1

[13] https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf See also: https://www.cmfblog.org.uk/2014/12/17/conscientious-objection-and-the-worrying-implications-of-the-glasgow-midwives-case/

[14] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

GMC guidance makes it clear that opting out of providing gender reassignment because of personal beliefs is permitted: doctors do not have to provide services or refer patients for 'gender reassignment', but they must not withhold treatments from transgender patients which they would provide to others (e.g. antibiotics, pain killers, infertility treatment etc).[15]

3.Training:

The Faculty of Sexual & Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists (RCOG)) used to refuse to award its family planning qualifications to any nurse, midwife or doctor who had a conscientious objection to certain (especially abortifacient) contraceptives. They changed their policy in 2017, relaxing their stance, so that now those with an ethical objection to certain procedures can obtain qualifications from which they were previously excluded.[16] It recognises that both the Human Rights Act 1998 and Equality Act 2010 offer some conscience protection in areas other than abortion and IVF. However, this is only guidance, it is not statutory.

It serves to highlight the controversy around freedom of conscience in some areas, in this case pressures to acquire specialist training and skills that health professionals are not comfortable with. While the guidance was changed in this case, it shows the fragility of freedom of conscience claims, especially for nursing and midwifery practitioners who have already found that their conscientious objection blocked their access to specialist training.

4.Examples/common questions CMF are asked by members:

Abortion

Nurse: *'I am currently studying the midwifery conversion course for nurses. I have a question regarding conscientious objection and what our rights are when it comes to providing/abstaining from giving care. I am on placement on the antenatal ward and because of staffing the bereavement ward has been closed and they now provide bereavement care (including terminations) amongst the antenatal care. Previously bereavement care has been provided by 'bereavement midwives' and when employed by the trust you were able to say if you were or were not happy to work on the bereavement ward. However, now they are training all midwives that work on the antenatal ward and expect them to be involved in all aspects of bereavement care. I was hearing a Christian midwife who works on the antenatal ward speak of how she has been told that if she is not happy to be involved in all aspects of bereavement care including terminations, then she is no longer able to work on the ward. She has now been moved to another area. Last week, I was asked to be involved in a termination for Downs Syndrome as it was suggested to be a 'good learning opportunity'. However, I spoke to my mentor and stated my reasons for not wanting to be involved in the termination regimen. She was understanding and because I am a student, I was able to step out of the situation. Do you know what our rights are as midwives and providers of care? I am interested* [to know] *for when I am qualified.*"

Student: *I am still a student doctor, however over the past months I have been experiencing high levels of anxiety, which has focused a lot on the current outlook for Christians in the NHS. I fear that a loss of the rights to conscientious objection and freedom of views will mean people perceive me and my practices as hindering people, rather than helping patients. I sometimes wonder how long I will enjoy the profession for and how I will deal with the intolerance of others.*

Gender re-assignment:

'A nurse was being told by her line manager to give puberty blocker injections to teens who wanted to change sex. After doing this a few times, her conscience really bothered her, so she asked not to have to do them. She

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[15] *For example, this means that you must not refuse to provide a patient with medical services because the patient is proposing to undergo, is undergoing, or has undergone gender reassignment. However, you may decide not to provide or refer any patients (including patients proposing to undergo gender reassignment) for particular services to which you hold a conscientious objection, for example, treatments that cause infertility. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice*

[16] https://www.fsrh.org/documents/guidance-for-those-undertaking-or-recertifying-fsrh/

was told that if she refused, she would be reported to the NMC and would be struck off. Rather than have that happen, she resigned. Was that inevitable or was her line manager correct?'

'A mental health nurse also was struggling last week as she's been forced to give out hormones in gender change children. Although she can talk with her manager about her concerns, legally I'm told she has no choice but to do it.'

Question 4: In your experience how would you characterise any barriers to participation? Are they related to lack of understanding, lack of representation, hostility to Christian beliefs, or other reasons?

Quote from member:
[Consultant]: '*There is hostility by dint of being Christian. It is a given that it is un-PC to criticise any other religion/ belief system, but completely acceptable in our current society to be hostile towards Christians, particularly evangelical Christians and to use the Lord's name in vain.'*

'The sense of living in a hostile UK environment with regard to being a Christian is not only watered down, and minimised as small compared to being an atheist or a Muslim; but in response evokes no protection or less emphasis in protected characteristics we have as a group compared to say trans (as government consults regularly with stonewall but less or not at all with other groups, in the case of the GRA)'

Members suggested that contributing factors to any experienced hostility to Christian beliefs includes a lack of religious literacy and a poor understanding of freedom of conscience and its protections. Added to this are work pressures and pressures on resources (such as the need for the NHS to find alternative cover for controversial roles/duties).

Question 5: Over the last 10 years do you think that the position of Christians in society has got easier, harder or remained the same? Please signify what you think has contributed to this.

The general sense is that the position of Christians in the medical work place has become harder. Some of the suggested reasons mentioned by members include:

Ignorance of the law and conscience protection and the way Institutions interpret it in their guidance and the principles. For example, draft GPhC guidance sought to replace a right to refer with a duty to dispense abortifacient contraceptives. This was changed when they were challenged on this, particularly in the light of the Equality Act. The final guidance allows pharmacists to practice in line with their religious and personal beliefs and have a right to refer.

A weakening of freedom of conscience. In particular the Doogan and Wood ruling and subsequent Nursing and Midwifery Council (NMC) guidance.[17] NMC guidance limits conscience protection to the Abortion Act conscience clause, read in its narrowest sense according to the judgement, as well as the HFE Act (which applies for fertility treatments). Both the Doogan and Wood ruling and the NMC guidance apply conscience protections narrowly now, which is contributing to the concerns and requests for advice as cited above from some CMF members, particularly nurses and midwives. This is relatively new. So, what has changed with legal precedent and the new Code is that freedom of conscience only applies to the immediate clinical care - a supervisor/manager does not have a right to not participate in supervising staff who are involved in a termination, nor the right not to book in or assess a patient being admitted for a termination. And if a nurse or midwife expresses their conscientious objection, they must do so to their line manager, colleagues and patients, and must refer their patient to another member of staff who is willing to take on their care.

The greater acceptance of abortion, emergency contraception and gender re-assignment procedures.

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[17] https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Increasing pressure on NHS resourcing, with the effect that some antenatal units have abortion patients and require staff who will do abortions.

There is a sense that of the Equality Act's nine protected groups, some characteristics are more protected than others, with religious beliefs being apparently relegated. This is perhaps less due to the Act itself but the way it is interpreted.

One member commented that it can be difficult to get public money for Christian causes:
(Psychiatrist): '*there is still a 'requirement' that Christian run community services must be faith-agnostic if they are ever to get any funding…Christians in the NHS need to feel able to recommend local faith-based resources without being seen as trying to proselytise.'*

Interestingly, in 2012 the GMC published a leaflet in conjunction with gay rights activist group Stonewall giving detailed advice about how to lodge a complaint against doctors who are felt to be discriminating against gay, lesbian and bisexual patients with Department of Health money too. However, they have not produced any similar leaflet for protecting faith groups from discrimination or conscience. This is just an example to illustrate that Christian doctors are not asking for special treatment but equal treatment.

Question 6: What steps could government and other public bodies take to make it easier for Christians to make a positive ongoing contribution to public life?

Refusal by employers to respect conscience places Christian employees in a difficult position by forcing them to act in a way they consider unethical. Alternatively, they may refuse to co-operate and risk dismissal.

CMF has offered advice to several medical professionals who have been put under pressure from their multi-disciplinary team or managers to be involved in the preparing patients for termination. We encourage members to explain their position in advance, to be clear on their duties and rights, and to negotiate their position within the team, trying to avoid conflict. If handled sensitively, this can usually reduce the risk of later difficulties and can head off avoidable conflict.

However, this requires mutual understanding on both 'sides' and requires some **reasonable accommodation** by the employer and team.

Regarding the particular pressure points for freedom of conscience (emergency contraception prescribing, gender reassignment, withdrawal of treatment/end of life decisions, abortion, and some infertility treatments) only abortion and infertility treatments are under statutory protection (Abortion Act and HFE Act 1990).

1.**Apply reasonable accommodation and extend statutory protection for freedom of conscience**

Reasonable accommodation of those who wish to conscientiously object is far better than forcing them to do things they believe are profoundly wrong. Applying the principle of reasonable accommodation will almost always succeed in protecting conscience without patients being denied access to services.[18]

Of course, Christians are not the only people who may hold strong moral views. Everyone has a set of beliefs or values – religious or otherwise – that influences the decisions they make. The appeal for reasonable accommodation is not 'special pleading' on behalf of a small minority of employees, but on behalf of all.

There is already sufficient access within the NHS to abortion and contraception and it is the responsibility of NHS institutions, rather than individuals, to provide it. It should therefore be possible to ensure that reasonable accommodation can be made for individual health professionals who do not wish to be involved – either directly or in the pathway - on conscience grounds.

[18] Reasonable accommodation in this setting describes practical changes made by an employer to a job description or work situation in order to protect the freedom of conscience of an employee.

However, to protect those who are not given reasonable accommodation we recommend extending freedom of conscience provision and making it statutory. In most areas there is no statutory CO protection at all so medical professionals rely on protection under the Equality Act, regulations and limited guidance.[19] For example, prescribing cross sex hormones and puberty blockers and withdrawal of treatment are not under statutory conscience protection.[20]

The most helpful conscience clause in UK law is in the HFE Act as it covers 'any activity' under the Act.

We would like to see all tasks that amount to arranging/facilitating and referring for abortion covered by the section 4(1) exemption, and not limited in the way interpreted by Hale in the Doogan and Wood judgement. Interestingly, the prior judgement to Hale's Supreme Court ruling was in the Scottish Court of Appeal, which ruled that freedom of conscience applies to *'whole process of treatment'*. This was overturned by Hale.

GMC guidance could be extended to other relevant health professionals (nurses and midwives, for example) as protection is better for doctors to practice healthcare in accordance with their consciences than for nurses and midwives under the NMC guidance.

2.**A better case needs to be made to help others understand how important freedom of conscience is.**

This could be done by using an argument from analogy using activities that virtually everybody in Parliament would find abhorrent, but which are permitted by some foreign regimes (e.g.. female genital mutilation, punitive amputation, torture, or other areas such as military service, hunting, refusing to take an oath on the bible). We need to help others to better understand that for some healthcare professionals being involved in abortion, embryo research or the withdrawal of life-sustaining treatment is morally equivalent to these other practices.

The right of conscientious objection is not a minor or peripheral issue. It goes to the heart of medical practice as a moral activity…. The right of conscience helps to preserve the moral integrity of the individual clinician, preserves the distinctive characteristics and reputation of medicine as a profession, acts as a safeguard against coercive state power, and provides protection from discrimination for those with minority ethical beliefs. Prof John Wyatt.[21]

3. **Spiritual Care**

The NMC Code does not mention spiritual care at all. Physical and psychosocial care certainly, but spiritual needs are dropped.[22] This reflects another disparity between GMC and NMC guidance with the former recognising the importance of spiritual care while the NMC fails to do so.

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[19] Employment equality regulations, religion of belief regulations, sexual orientation regulations, GMC guidance and BMA guidance. The British Medical Association defends conscientious objection only in three specific scenarios. It '*should ordinarily be limited to those procedures where statute recognises their right (abortion and fertility treatment) and to withdrawing life-prolonging treatment from patients who lack capacity, where other doctors are in a position to take over the care*.' https://www.bma.org.uk/advice/employment/ethics/expressions-of-doctors-beliefs

[20] Decisions about withdrawal of treatment are usually taken and executed by senior doctors. We have not at CMF been contacted by any members who have faced discrimination or coercion in these areas.

[21] https://www.cmf.org.uk/resources/publications/content/?context=article&id=25406

[22] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf