PUBLIC RECORD

Dates: 19/10/2026 - 03/11/2026

Doctor:	Dr Syeda SIDDIQUI
GMC reference number:	2954651
Primary medical qualification:	MRCS 1984 Royal College of Surgeons of England

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome
Suspension, 6 months
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Francesca Martin
Lay Tribunal Member:	Mr Mark O'Brien
Registrant Tribunal Member:	Dr Richard Vautrey

Tribunal Clerk:	Ms Sara Nagpal

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Vivienne Tanchel, instructed by MDDUS
GMC Representative:	Mr Hugh Barton, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 28/10/2026

1. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

Background

2. Dr Syeda Siddiqui qualified as a doctor in 1984 from the University of Manchester. Prior to the events which are the subject of the hearing, Dr Siddiqui has had a career in Ophthalmology at various hospitals as a SHO and as a registrar. At the time of the events, she was practicing as a consultant at the Community Health & Eye Care Centre 'CHEC' in Stockport on a part-time basis.

3. The allegations that have led to Dr Siddiqui's hearing relate to her clinical performance, specifically to infection control, and alleged dishonesty. It is alleged by the General Medical Council (GMC) that Dr Siddiqui undertook examinations of Patient A, Patient B and Patient D while wearing non-sterile gloves which were stained with blood. She is also accused of repeatedly breaching basic infection control practices. The allegations of dishonesty are that Dr Siddiqui sought to collect non-sterile medical instruments from the hospital and misrepresented that she had authorisation to do so, which was dishonest. Further, Dr Siddiqui referred to the examination of Patient D with blood-stained gloves as an isolated incident, which was dishonest.

4. The initial concerns were raised with the GMC on 10 December 2024 by a patient, who was examined by Dr Siddiqui while she wore bloodstained gloves and subsequently escalated the issue.

The outcome of applications made during the facts stage

5. The Tribunal granted Dr Siddiqui's application, made pursuant to Rule 34 of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules), to adduce further evidence in the form of Dr Siddiqui's CV. The GMC had no opposition to the matter.

6. The Tribunal granted the GMC's application, made pursuant to Rule 34 of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules), to adduce further evidence in the form of another version of Dr Siddiqui's CV. That application was opposed. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's response

7. The Allegation made against Dr Siddiqui is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 7 August 2024 you were undertaking a minor operations list at Community Health & Eyecare Ltd Clinic ('CHEC'), Warrington. Admitted and found proved

2. When undertaking an examination of Patient A's eye you wore non-sterile gloves which were contaminated with blood from a different patient that you had treated earlier. To be determined

3. When undertaking an examination of Patient B's eye you wore non-sterile gloves that were contaminated with blood from a different patient that you had treated earlier. Admitted and found proved

4. When you acted in the manner described at paragraphs 2 and 3 above, you:

a. entered and exited the operating theatre wearing used non-sterile gloves;
To be determined

b. contaminated everything you touched with the used non-sterile gloves.
To be determined

5. During the examinations described at paragraphs 2 and 3 above, you were spoken to on one or more occasion for not using proper hygiene procedures but you continued not to:

i. change your gloves after treating each patient; To be determined
ii. perform hand hygiene between treating/examining patients.
To be determined

6. On 7 August 2024, you:

a. asked Nurse C to keep non-sterile medical instruments so that you could take them home; Admitted and found proved
b. collected used non-sterile medical equipment in a container so that you could take them home; Admitted and found proved
c. stated this was the normal practice at the Stockport branch of CHEC, or words to that effect. Admitted and found proved

7. You had not been authorised to take non-sterile equipment home at CHEC, Stockport. To be determined

8. You knew you had not been authorised to take non-sterile equipment from CHEC, Stockport. To be determined

9. Your conduct at paragraph 6c is dishonest by reason of paragraph 7 and 8.
To be determined

10. On 10 December 2024 when undertaking a minor operations list at CHEC, Stockport, you:

a. medically examined Patient D's eyelids with non-sterile gloves that were contaminated with blood from another patient; Admitted and found proved

b. failed to remove your gloves after treating another patient. Admitted and found proved

c. stated this was an isolated incident, or words to that effect, when challenged about the gloves despite having:

i. been spoken to by Nurse C about the same conduct on 7 August 2024; To be determined

ii. attended a meeting with Mr E to discuss the use of non-sterile equipment in the week commencing 12 August 2024. To be determined

11. When you made the remark that this was an isolated incident as described at paragraph 10 c, you knew the information was untrue. To be determined

12. Your conduct at paragraph 10c was dishonest by reason of paragraph 11. To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

The Admitted facts

7. At the outset of these proceedings, through her Counsel, Ms Vivienne Tanchel, Dr Siddiqui made admissions to several paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs of the Allegation as admitted and found proved.

Witness evidence

8. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Ms F, Theatre Practitioner Nurse at CHEC Warrington. Her witness statement is dated 30 April 2025
- Ms G, Hospital Manager at the Stockport site of CHEC Ophthalmology Hospital. Her witness statement is dated 28 April 2025
- Mr H, Clinical Director for Ophthalmology and a Consultant Ophthalmologist at CHEC. His witness statement is dated 2 May 2025
- Mr I, registered Operating Department Practitioner at CHEC Trafford. His witness statement is dated 14 July 2025
- Ms J, Theatre Practitioner and infection control lead at the CHEC Ophthalmology Hospital at the Warrington site. Her witness statement is dated 23 April 2025

10. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms L, Theatre Nurse at CHEC Stockport. Her witness statement is dated 29 April 2025.

9. Dr Siddiqui provided her own witness statement dated 13 September 2026 and gave oral evidence at the hearing.

Expert witness evidence

10. The Tribunal also received evidence from an expert witness, Mr K. B.Sc. (Med Sci), MB ChB, FRCOphth on behalf of the GMC. The expert report was dated 30 October 2025. Mr K is a consultant ophthalmologist. His evidence assisted the Tribunal in understanding the professional standards expected of a consultant ophthalmologist and whether they were adhered to in the case of Dr Siddiqui.

Documentary evidence

11. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, the following:

- Incident reports document numbers IN_07686 and IN_07688 pertaining to 7 August 2024
- Email from Mr H, pertaining to 7 August 2024, dated 11 December 2024
- Email from Mr I, to Mr M and Ms N dated 16 August 2024
- WhatsApp messages between Dr Siddiqui and Ms G from CHEC
- Email chain between Ms J and Mr O
- CHEC infection control policy
- Dr Siddiqui's two CVs
- Testimonial bundle containing 15 witness statements relevant to Dr Siddiqui's character.

The Tribunal's approach

12. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of

proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

13. The Tribunal will approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal will then consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The Tribunal should not decide reliability and credibility based on the demeanour of a witness alone.

14. During the proceedings, it was established that Dr Siddiqui was entitled to a modified good character direction. The Tribunal considered that Dr Siddiqui has no fitness to practice history but for the admissions she made. It further acknowledged that it received no less than 15 testimonials affirming Dr Siddiqui's good character. Dr Siddiqui, being of previous good character may be less likely than otherwise to have acted in the matters as alleged. Second, her evidence of good character holds bearing upon her credibility and reliability as those matters are keenly in dispute.

15. However, the Tribunal reminded itself that good character is not determinative. It considered the allegations Dr Siddiqui admitted to and evaluated the weight given to testimonials. Good character is a matter for the Tribunal's judgment, having regard to the evidence and the circumstances of the case.

16. The Tribunal reminded itself that it must form its own judgment about the evidence presented to it. The Tribunal was mindful that its task at this stage is to consider the evidence and submissions and make findings in relation to the factual allegations in dispute. Each paragraph of the Allegation must be considered separately and in turn.

The Tribunal's analysis of the evidence and findings

Agreed facts

17. The Tribunal first approached the evidence to see whether there were areas of agreement, either expressly agreed facts or those that could reasonably be inferred from the agreed evidence.

18. The common areas of agreement can be summarised as follows:

i. At the time of the alleged events, Dr Siddiqui had more than 30 years of experience in Ophthalmology.

ii. Dr Siddiqui had worked as an ophthalmologist performing oculoplastic surgery before she joined CHEC.

iii. Hand hygiene and infection control guidance is a key part of mandatory training for any medical practitioner. Dr Siddiqui will have had training in the importance of hand hygiene and infection control procedure in relation to her medical training.

iv. Examining patients by touching any part of their body with blood-stained gloves, where that blood belongs to another patient, falls seriously below the standard expected of a reasonably competent Consultant Ophthalmologist. The Tribunal considered the expert witness statement which reads:

'The practice presents several serious infection control risks. The primary concern is cross contamination of blood-borne infection. Pathogens present on the contaminated gloves can be transferred to the patient, other healthcare staff or surfaces, creating a potential vector for healthcare-associated infection. The practice breaches universal precautions and standard infection prevention protocols, under UK standards set by the Health and Social Care Act 2008 (Regulated Activities) Regulations and NHS Infection Prevention and Control Guidelines.'

v. Patient A and B were being examined pre-operatively at the times relevant to the Allegation.

vi. On 7 August Dr Siddiqui worked in the minor operations list with Ms F, Mr I and Ms J.

vii. Dr Siddiqui had a good working relationship with Ms J; she had no prior working or personal relationship established with Ms F nor Mr I.

viii. Dr Siddiqui was working with a charity separate to her work with CHEC. The charity collected and sent medical instruments overseas. Dr Siddiqui understood that the medical institutions receiving the instruments had the means to sterilise them.

ix. On 7 August, Dr Siddiqui asked Nurse C to keep some of the non-sterile equipment aside for her to take. Nurse C subsequently escalated the issue, and it forms the subject matter of incident report IN_07688.

x. It is never appropriate practice to take home used surgical instruments under any circumstances. Surgical instruments, once used, are classified as clinical waste and contaminated medical devices, and are subject to strict decontamination, tracking and disposal or sterilisation protocols governed by UK infection control law and health service regulations.

xi. Incident reports number IN_07686 and IN_07688 were completed at some point after 7 August and before 14 August 2024.

xii. The said incident reports were initially filled in by Ms J with contribution from Ms N.

xiii. Mr I's email regarding the alleged infection control incident on 7 August 2024 was sent to Mr M and Ms N on 16 August 2024.

xiv. The statement of Ms J for CHEC was made around the time of the incident investigation report, likely within days of 7 August 2024.

19. Noting the passage of time since the events alleged to have occurred on 7 August 2024 and 10 December 2024, oral evidence being given in the week commencing 19 October 2026, the Tribunal placed the greatest weight on the contemporaneous documentary evidence and the accounts or emails sent close to the time of the events and then went on to consider all other evidence.

20. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

Paragraph 2

21. The Tribunal considered that Incident Report IN_07686 was likely the most contemporaneous document relevant to this allegation. The document records that Ms F witnessed Dr Siddiqui examine a patient on the slit lamp in the room adjacent to the theatre whilst wearing the same gloves she had worn for the previous patient's minor op procedure. The Tribunal considered the oral and written evidence offered by Ms F and found it to be

inconsistent on one issue, pertaining to whether Patient A was pre-operative or post-operative. In her written statement provided to the GMC, dated 30 April 2025, Ms F described Patient A as post-operative at the time they were allegedly examined with blood-stained gloves. Noting that the allegation was that the gloves were contaminated with blood from a different patient, the Tribunal considered whether Miss F may be right in her GMC statement and Patient A may have been post-operative and so the blood may have belonged to Patient A. However, it was not advanced by the doctor that Patient A was post-operative and the evidence in the round suggested that being examined on a slit lamp, Patient A would have likely been pre-operative. Therefore, the blood, if present on Dr Siddiqui's gloves, would probably have belonged to a different patient.

22. The Tribunal however placed little weight on the witness statement and oral evidence of Ms F, beyond accepting that Ms F and Dr Siddiqui do not know each other well or have any ill-will between them and hence, Ms F has no motive to provide inaccurate evidence nor did she have any reason to impart the information which she did to Ms J who then completed IN_07686 with her report of events.

23. The Tribunal found that the account in the incident report was the most reliable source of evidence as to what occurred in relation to paragraph 2 of the allegation. The Tribunal were not assisted by Dr Siddiqui's oral and written evidence which maintained no recollection of the alleged event.

24. The Tribunal noted that in addition to the direct evidence going to paragraph 2, Dr Siddiqui's admission of allegation 3 concerned the same alleged conduct. The Tribunal found the allegation proved.

Paragraph 4

25. In relation to allegation 4 the Tribunal considered the witness statement of Dr Siddiqui which reads:

> *'I deny 4 a. as I simply do not recall if I entered and exited the operating theatre wearing non-sterile gloves, but I accept that, if I did that, I would have contaminated everything I touched.'*

26. The Tribunal then considered the incident report IN_07686 that reads:

'Following this incident, another nurse ([Mr I) assisting with MOPs list on identified that SSA was exiting and entering the theatre and discharge room with what was thought to be contaminated gloves on. This was then raised to another nurse (Ms J) assisting in the MOPs list who then left the theatre and went into the discharge room where SSA was examining another patient to identify if the gloves were in fact contaminated.'

27. The Tribunal further considered evidence given by Mr I about paragraph 4 of the allegation. The Tribunal found Mr I to be a reliable witness, noting that he took it upon himself to escalate an infection control incident on 16 August 2024 against a consultant doctor while having joined CHEC recently. His witness statement provided to the GMC and dated 14 July 2025, reads:

'After the procedure, I saw Dr Siddiqui walk from the operating theatre into the clinical room while still wearing the same pair of surgical gloves (gloves).'
…
'Dr Siddiqui was not only examining patient while wearing visibly soiled gloves, but she was also contaminating everything she touched in process of moving from the operating theatre to the clinical room, such as door handles, worktops, and medical devices.'

28. Whilst the documentary evidence provided by Mr I was consistent, the Tribunal placed greater weight on Mr I's email dated 16 August 2024 since this was completed closer in time with the events. With regards to allegation 4a, the Tribunal noted that the evidence of Mr I and Ms F focused on Dr Siddiqui exiting the theatre and entering the discharge room with non-sterile gloves when examining Patients A and B. However, there was no evidence to suggest that Dr Siddiqui entered the theatre wearing the blood-stained gloves specifically prior, during or after her examination of Patents A and B. Hence, allegation 4a was not proved.

29. Turning to allegation 4b, the Tribunal noted that where allegations 2 and 3 were found proved, it follows that Dr Siddiqui will have contaminated everything she touched. It could be reasonably inferred that the handle between the theatre and the discharge room and the slit lamp would have been contaminated. Hence, allegation 4b was proved.

Paragraph 5

30. The Tribunal noted that Mr I statement to the GMC reads:

'I was present when [Ms J] told Dr Siddiqui to remove her gloves and wash her hands before and after treating patients. Dr Siddiqui said she would comply, but she continued to neglect

proper hand hygiene procedures and failed to remove her gloves or perform hand hygiene between treating/examining patients throughout the day.'

31. The Tribunal found that this aligned with Ms J's statement which states, in relation to the incident with Patient B:

'I then noticed that SSA continued to fail to remove her contaminated gloves. Following the next procedure SSA tried to leave theatre to go in to examine another patient in the discharge room whilst still wearing contaminated gloves from the previous patient...'

32. The Tribunal considered the fact that Dr Siddiqui admitted allegation 3 and accepted that she was given new gloves by Nurse C in relation to patient B. In the circumstances, the Tribunal having accepted that during the examination of Patient A, Ms F intervened as Dr Siddiqui was examining the patient with blood-stained gloves, allegation 4 is proven by the fact that allegation 3 occurred at all. In addition, the Tribunal also noted the evidence of Ms J, contained in her statement to CHEC which recorded that, after changing her gloves to examine Patient B, Ms J:

"then noticed that [Dr Siddiqui] continued to fail to remove her contaminated gloves".

Hence, paragraph 5 i and ii of the allegation was found proved.

Paragraph 7

33. The Tribunal considered the agreed evidence of the expert witness, Mr K which provided:

' In my opinion, it is never appropriate to take home used surgical instruments under any circumstances. Surgical instruments, once used, are classified as clinical waste and contaminated medical devices, and are subject to strict decontamination, tracking and disposal or sterilisation protocols governed by UK infection control law and health service regulations. Under the Health and Social Care Act 2008 (Regulated Activities) Regulations, COSHH (Control of Substances Hazardous to Health) Regulations 2002, and HTM 01-01 Decontamination Guidance (please see appendix B), used instruments must be transported, cleaned, disposed of or sterilised only within approved facilities equipped to handle biohazardous material safely.

...

Taking instruments home constitutes a serious breach of infection prevention standards, risks cross-contamination and exposure to bloodborne pathogens. It also raises legal and

data governance issues, as such instruments are hospital property even if they are disposable.'

34. The Tribunal considered it was therefore unlikely that Dr Siddiqui would have been authorised to take non-sterile equipment home. However, this was rebuttable, subject to the evidence. Dr Siddiqui, exhibiting WhatsApp messages to her witness statement, provided evidence that she had been provided with inferred permission from Ms G in May 2024 to take unused surgical instruments from CHEC to donate to charitable causes abroad. However, she advanced no evidence that she had been authorised to take used surgical instruments. She could provide no cogent evidence of having sought such authorisation from senior management or receiving it. In her oral evidence, Dr Siddiqui described a conversation with Mr H regarding the matter, where he expressed his enthusiasm for the idea and expressed his intention to, "look into it". It was the view of the Tribunal that this fell short of authorisation. The Tribunal found both Mr H's and Dr Siddiqui's evidence to be unclear on the content of any discussions between them. Hence, the Tribunal found paragraph 7 of the allegation proved.

Paragraph 8

35. The Tribunal considered the oral evidence of Dr Siddiqui that she was under the impression that Mr H, Ms G and the nursing staff knew she was collecting non-sterile equipment for charity. However, that evidence fell short of demonstrating express authorisation to do so from anyone in a senior position as it pertained to used surgical instruments. Dr Siddiqui accepted that she had not made the distinction between used and unused surgical equipment when mentioning the matter to Mr H.

36. The Tribunal concluded that Dr Siddiqui must have known that she had not been authorized to take non-sterile equipment from CHEC, Stockport. Hence, paragraph 8 of the allegation was found proved.

Paragraph 9

37. When considering her subjective state of mind, the Tribunal considered that Dr Siddiqui was probably operating under the assumption that she did not need authorisation from Mr H or anyone in a similar position of authority, to collect non-sterile equipment. The Tribunal noted that Dr Siddiqui made no effort to conceal her collections. It also considered the evidence offered by Ms G, noting that Dr Siddiqui stopped collecting the instruments readily once she was asked not to.

38. The Tribunal considered that Dr Siddiqui believed her collection of non-sterile instruments were normal practice at the Stockport branch of CHEC.

39. In accordance with the stage 2 test for dishonesty outlined in Ivey v Genting Casinos, the Tribunal considered that Dr Siddiqui's subjective knowledge meant that by ordinary standards, her conduct at paragraph 6c was not dishonest. Hence, paragraph 9 of the allegation was not proved.

Paragraph 10c

40. Under cross-examination and in her witness evidence, Dr Siddiqui accepted that she may have used the words 'isolated incident' although she had no recollection of doing so. The Evidence of Ms G in her statement for CHEC completed in December 2024 and her witness statement for the GMC, dated April 2025 and her oral evidence to the Tribunal under cross-examination was consistent that Dr Siddiqui stated that the examination of Patient D was an isolated incident. The Tribunal was satisfied that that Dr Siddiqui did state that the examination was an isolated incident.

41. The Tribunal turned to paragraph C i, and considered the evidence given by Dr Siddiqui. Her position was that she remembered being handed gloves by nurse C but did not recall any details of the conversation. The Tribunal were persuaded by the evidence of Ms J and other theatre staff as to the fact and content of a similar conversation on 7 August 2024. Hence, paragraph 10 C i of the allegation was found proved.

42. In relation to a meeting with Mr H and Dr Siddiqui, the Tribunal began with the contemporaneous documents. The Tribunal placed weight upon the incident report, IN_07688, completed around 13 August 2024, which references an interaction between Mr H and Dr Siddiqui. In the report, Ms R writes:

> *'[Ms R] discussed with [Ms P] (IPC lead). Staff should challenge clinicians when they are not changing their gloves or washing their hands in between patients. Quality Governance to monitor recurrence with clinician involved. [Mr H] has also communicated with the clinician that this is not acceptable practice.'*

43. The Tribunal found it unlikely that Mr H would falsify the fact of a meeting/ communication between him and Dr Siddiqui, especially one he spoke to his colleagues about and was formalised into an incident report.

44. The Tribunal did not afford weight to the content of Mr H's email dated 11 December 2024 which was clearly written in retrospect when the lack of any record of the meeting with Dr Siddiqui was highlighted by supervening events.

45. The Tribunal considered Dr Siddiqui's oral evidence on the issue of whether a meeting took place. She was consistent throughout questioning and maintained that she doesn't remember a meeting or words to that effect and challenged why there was no HR attendance or documentation.

46. The Tribunal found Mr H's evidence under cross-examination to be defensive and noted that there was no contemporaneous record of any meeting that Dr Siddiqui attended. Whilst the incident report noted that Mr H had communicated with the clinician and the Tribunal accepted that some communication did take place, it was not persuaded that an informal and unrecorded contact would be regarded as 'attending a meeting.' This is particularly so, giving the wording of the allegation a normal interpretation by a reasonable member of the public. It is the Tribunal's view that the GMC has failed to prove its case on this issue. Hence, paragraph 10C ii was not found proved.

Paragraph 11

47. The Tribunal considered the reliability of Dr Siddiqui as a witness and the modified good character direction. The Tribunal noted that Dr Siddiqui denied the content of the conversations detailed by both Ms G and Ms J set out below. Both individuals had a good working relationship with Dr Siddiqui and continued to speak highly of her in their oral examination. They clearly respected Dr Siddiqui, which lent weight to their evidence, particularly where their accounts were corroborated by contemporaneous documents. The Tribunal first considered the most contemporaneous account by Ms G in relation to Patient D, completed in the days following 10 December 2024. In her statement for CHEC, Ms G documented:

> *"I asked Syeda why there was blood on her gloves and she told me she had forgotten to take them off after the previous patient. I told Syeda that she should be removing and disposing of gloves between each patient. Syeda agreed but said that it was a mistake and an isolated incident, and that she is not sure why she forgot to remove them on this occasion. I asked Syeda if she touched the patient whilst wearing the gloves and she said that she did not touch the patient, she just went through the consent form".*

48. The Tribunal then considered the witness statement of Ms G dated 28th April 2025 which reads:

'As detailed in Exhibit EB1, I asked Dr Siddiqui why there was blood on her gloves, and she said it was an oversight, and she forgot to take them off. I asked her if she touched [Patient D] with the gloves, and she responded ''No". I would like to clarify that I asked her again to confirm that she did not touch Patient D, and she responded, "No, I just went through the consent forms". The above reflects my best recollection of what was said, as I do not remember the exact conversation.

…

As mentioned in Exhibit EB1, after had left, I returned to speak with to Dr Siddiqui. I would add that she was visibly shaken. I told her that had told me that there was "Blood all over," which was not what we discussed. I told Dr Siddiqui we needed to halt the Minor Operations Clinic list, but she seemed reluctant. I explained that I needed to seek advice and escalate the incident. Dr Siddiqui appeared resistant and worried because she kept saying it was an isolated incident, that it would not happen again, and that she did not realise. I said that as the registered manager, I had an obligation to halt the list to seek advice and escalate the incident. I then called the infection control lead, [Ms P] and while on the phone, asked a team member, [Ms Q], to halt the list and cancel the appointments.'

49. In oral evidence, Ms J was consistent with her written evidence and made appropriate concessions under cross-examination as she had disclosed in her GMC statement, accepting that she did not remember the exact conversation and she could not speak to Dr Siddiqui's intention when she described the incident as isolated.

50. Dr Siddiqui, through her counsel, submitted that she would not have denied touching the patient as it was obvious that she would have had to touch her to examine her. Ms G was being informed of the Patient's distress in order to go and speak with the patient, therefore there was no point minimising or concealing what had happened. However, the Tribunal thought it more likely that Dr Siddiqui made a poor decision to misrepresent matters in the heat of the moment rather than that Ms G would make up a conversation that did not take place. Indeed, in oral evidence, Ms G described Dr Siddiqui as "one of the best doctors I have ever worked with".

51. The Tribunal proceeded to consider Dr Siddiqui's denial of the conversation purported to have taken place with Ms J, wherein Dr Siddiqui said that she would keep the same gloves to avoid having to wash her hands. The contemporaneous evidence of this is in the incident report where Ms J has documented Dr Siddiqui said "*This is how I normally do it, it saves me washing my hands".*

52. The Tribunal next considered the GMC witness statement of Ms J dated 23 April 2025 which read:

> *"Dr Siddiqui and the patient came in together and [Mr I] was already in the theatre room, so he helped the patient on to the bed and talked to them. Although I do not remember exactly what was said but I pulled Dr Siddiqui to the side and said, "do you understand why I asked you for the gloves?" and she said, "I didn't realise but there was something on the gloves, I understand, and I have changed them now". I asked her again "but do you understand why you can't wear the same gloves; you have to take them off and wash your hands". She responded saying I was not going to take the gloves off because it saves time and means I don't need to wash my hands" to which I responded saying, "but you should be washing your hands and changing your gloves". She then said, "I take it you're going to parent me today, are you, my mother?" and I responded saying "Yes, if I have to be". The conversation did not take too long, it could have been five minutes, she thought that she did not need to wash her hands because of the gloves."*

53. Ms J was unmoved under cross-examination as to this discussion regarding hand hygiene. She was clear that Dr Siddiqui thought the gloves were for her own protection and the conversation suggested she wasn't cognisant of the need to protect patients.

54. The Tribunal found Ms J and Ms G to be reliable witnesses and drew an adverse inference about Dr Siddiqui's credibility from her denial of the conversations detailed by Ms J and Ms G. However, the Tribunal noted that credibility could be divisible and just because Dr Siddiqui was not credible on the content of these conversations, it did not necessarily mean her other evidence was incredible.

55. Focusing upon the reference of the events pertaining to Patient D on 10 December 2024 as an isolated incident, the Tribunal considered the evidence given by Dr Siddiqui and noted that her oral evidence departed from her written witness statement. Dr Siddiqui asserted in her oral evidence that she meant the infection control risk was isolated to the discharge room and a different room could be used for examinations. The Tribunal considered that Dr Siddiqui had had ample opportunity to clarify what she meant by the word 'isolated.' This evidence under cross-examination was new and suggested that Dr Siddiqui was trying to create an acceptable explanation for her words rather than giving her truthful recollection to the Tribunal.

56. Overall, with regards to the words 'isolated incident' being used, the Tribunal appreciated that 'isolated' could have numerous interpretations. However, it deemed it more

likely than not that Dr Siddiqui was minimising the event pertaining to patient D at the time she spoke to Ms G, denying having touched the patient and describing it as an 'isolated incident'. The Tribunal were of the view that Dr Siddiqui cannot have failed to recall the events of 7 August 2024 and was aware that she was being untruthful. Hence, paragraph 11 of the allegation was found proved.

Paragraph 12

57. As per the test for dishonesty in Ivey v Genting Casinos [2017] UKSC 67: When dishonesty was in question, the fact-finding tribunal had to first ascertain, subjectively, the actual state of the individual's knowledge or belief as to the facts. The reasonableness of that belief was a matter of evidence going to whether they had held the belief, but it was not an additional requirement that the belief had to be reasonable; the question was whether it was genuinely held. When the state of mind was established, the question whether the conduct was honest or dishonest was to be determined by applying the objective standards of ordinary decent people. There was no requirement that the defendant must appreciate that the conduct was dishonest by those standards.

58. The Tribunal considered whether Dr Siddiqui had acted dishonestly, applying the test in Ivey v Genting Casinos. To determine Dr Siddiqui's subjective state of mind when describing having touched Patient D with blood stained gloves as an isolated incident, the Tribunal considered Dr Siddiqui's experience and seniority as a doctor and found it unlikely that she did not recall previous warnings about infection control compliance given to her in August 2024 by Ms J and Mr H.

59. It is unlikely that subjectively, Dr Siddiqui was referring to the event being isolated in time, because under cross-examination she gave an alternative interpretation, that she was referencing the event being isolated in space.

60. The Tribunal considered that on the balance of probabilities, it was more likely than not that Dr Siddiqui was aware that this was not an isolated incident. Describing it as so was likely not a genuinely held belief but rather as a 'knee-jerk reaction' to being confronted by Ms G, just as she had denied touching Patient D when, with more careful analysis, such an untruth would be uncovered. The Tribunal found it highly improbable that Dr Siddiqui had forgotten numerous conversations with colleagues including Ms J, Ms F and Mr H, notwithstanding that the latter communication was not formalised into a scheduled meeting attended by HR. While the Tribunal remained mindful of the modified good character direction, it further noted that several of the testimonials in favour of Dr Siddiqui came from family members and Ms G and

Ms J both spoke highly of her despite her actions which form the subject matter of the allegations. Hence, paragraph 12 of the allegation was found proved.

The Tribunal's overall determination on the facts

That being registered under the Medical Act 1983 (as amended):

1. On 7 August 2024 you were undertaking a minor operations list at Community Health & Eyecare Ltd Clinic ('CHEC'), Warrington. Admitted and found proved

2. When undertaking an examination of Patient A's eye you wore non-sterile gloves which were contaminated with blood from a different patient that you had treated earlier. Determined and Found Proved

3. When undertaking an examination of Patient B's eye you wore non-sterile gloves that were contaminated with blood from a different patient that you had treated earlier. Admitted and found proved

4. When you acted in the manner described at paragraphs 2 and 3 above, you:

    a. entered and exited the operating theatre wearing used non-sterile gloves; Not proved
    b. contaminated everything you touched with the used non-sterile gloves. Determined and Found Proved

5. During the examinations described at paragraphs 2 and 3 above, you were spoken to on one or more occasion for not using proper hygiene procedures but you continued not to:

    i. change your gloves after treating each patient; Determined and Found Proved

    ii. perform hand hygiene between treating/examining patients. Determined and Found Proved

6. On 7 August 2024, you:

    a. asked Nurse C to keep non-sterile medical instruments so that you could take them home; Admitted and found proved

b. collected used non-sterile medical equipment in a container so that you could take them home; Admitted and found proved

c. stated this was the normal practice at the Stockport branch of CHEC, or words to that effect. Admitted and found proved

7. You had not been authorised to take non-sterile equipment home at CHEC, Stockport. Determined and Found Proved

8. You knew you had not been authorised to take non-sterile equipment from CHEC, Stockport. Determined and Found Proved

9. Your conduct at paragraph 6c is dishonest by reason of paragraph 7 and 8. Not Proved

10. On 10 December 2024 when undertaking a minor operations list at CHEC, Stockport, you:

a. medically examined Patient D's eyelids with non-sterile gloves that were contaminated with blood from another patient; Admitted and found proved

b. failed to remove your gloves after treating another patient. Admitted and found proved

c. stated this was an isolated incident, or words to that effect, when challenged about the gloves despite having:

i. been spoken to by Nurse C about the same conduct on 7 August 2024; Determined and Found Proved

ii. attended a meeting with Mr E to discuss the use of non-sterile equipment in the week commencing 12 August 2024. Determined and found not proved

11. When you made the remark that this was an isolated incident as described at paragraph 10 c, you knew the information was untrue. Determined and Found Proved

12. Your conduct at paragraph 10c was dishonest by reason of paragraph. Determined and Found Proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

Determination on Impairment - 30/10/2026

61. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

The evidence

62. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received a stage two bundle from Dr Siddiqui including several CPD certificates and a reflective statement dated 29 October 2026.

Submissions on behalf of the GMC

63. On behalf of the GMC Mr Hugh Barton, Counsel, directed the Tribunal to the Guidance for MPTS Tribunals published on 30 September 2025 (Guidance henceforth) and the sections relevant to stage two: impairment.

64. Mr Barton submitted that all the allegations found proved by the Tribunal at the facts stage were constitutive of misconduct sufficient to ground a finding of impairment. He summarised the allegations which had been admitted by Dr Siddiqui and those which had been found proved by the Tribunal and directed it to the relevant parts of the guidance on impairment.

65. Mr Barton asserted that in the case of Dr Siddiqui, her misconduct is linked to clinical concerns. He directed the Tribunal to paragraph 21 from the guidance which reads:

> *'21. In a clinical concerns case, expert evidence will often have been presented to the MPT at the facts stage where the allegation relates to the doctor's performance. Where available, it can be used to inform the MPT's view on seriousness based on the extent of the departure from the professional standards.'*

66. With regards to the clinical concerns of infection control, Mr Barton reminded the Tribunal of Mr K's unchallenged expert opinion that the examination of a patient with gloves

stained with blood belonging to another patient fell "seriously below the standard expected of a reasonably competent Consultant Ophthalmologist". Mr K's evidence was that:

> *'The practice presents several serious infection control risks. The primary concern is cross contamination of blood-borne infection. Pathogens present on the contaminated gloves can be transferred to the patient, other healthcare staff or surfaces, creating a potential vector for healthcare-associated infection. The practice breaches universal precautions and standard infection prevention protocols, under UK standards set by the Health and Social Care Act 2008 (Regulated Activities) Regulations and NHS Infection Prevention and Control Guidelines.'*

67. Mr Barton submitted that not only did Dr Siddiqui's actions carry risk of patient harm, but also caused substantial distress and anxiety to patient D.

68. With regards to the collection of non-sterile medical equipment, Mr Barton submitted that this, too, fell, "seriously below the standard expected of a reasonably competent consultant ophthalmologist" as per the unchallenged opinion of Mr K. Mr Barton directed the Tribunal to the relevant content of Mr K's report:

> *' In my opinion, it is never appropriate to take home used surgical instruments under any circumstances. Surgical instruments, once used, are classified as clinical waste and contaminated medical devices, and are subject to strict decontamination, tracking and disposal or sterilisation protocols governed by UK infection control law and health service regulations. Under the Health and Social Care Act 2008 (Regulated Activities) Regulations, COSHH (Control of Substances Hazardous to Health) Regulations 2002, and HTM 01-01 Decontamination Guidance (please see appendix B), used instruments must be transported, cleaned, disposed of or sterilised only within approved facilities equipped to handle biohazardous material safely.'*

69. Mr Barton submitted that these breaches of infection control policy represented serious departures from good medical practice, amounting to misconduct.

70. With regards to factors increasing the level of seriousness, Mr Barton submitted that the misconduct was aggravated by repetition. He noted that while issues regarding infection control and hand hygiene were raised with Dr Siddiqui in August 2024, the behaviour reoccurred in December of the same year.

71. With reference to Dr Siddiqui's dishonesty finding, Mr Barton conceded that it was a single incident, set against a long and unblemished career. However, he submitted that any finding of dishonesty in a clinical setting with an intent to minimise and misrepresent the Doctor's own misconduct must be regarded as serious. He further directed the Tribunal to paragraphs 77, 80 and 87 of the Guidance that read:

> *'77. Honesty is a basic quality that is expected of all, based on shared moral values. It involves being truthful about important matters and respecting the property rights of others. Dishonesty is a disregard for this shared moral value and can be used to describe a lack of probity, cheating, lying or deliberately withholding information.'*
>
> *…*
>
> *'80. Honesty is at the heart of medical professionalism and is essential for the public to have trust in doctors and the systems they work in. Doctors must make sure their conduct justifies their patients' trust in them and the public's trust in the profession. They must follow the law and always be honest about their experience, qualifications and current role.'*
>
> *…*
>
> *87. 'Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.'*

72. Mr Barton reminded the Tribunal that they must consider the impact of any relevant context on the misconduct. He noted that Dr Siddiqui made references to a problematic work environment which involved excessively long lists, short consultation times, administrative issues and other sub-optimal conditions in her witness statement and oral evidence. However, Mr Barton submitted that Dr Siddiqui is an experienced clinician, and if there were conditions that raised patient safety concerns, she had the ability to raise those issues. He further reminded the Tribunal about the evidence of Ms G, who did not accept the chaotic picture portrayed by Dr Siddiqui.

73. In terms of Dr Siddiqui's insight and remediation, Mr Barton noted that she admitted to certain allegations while denying others. She also expressed remorse during her oral evidence. However, bearing in mind her seniority and experience, Mr Barton invited the Tribunal to consider if repeated breaches of fundamental infection control measures were caused by a genuine lack of training and knowledge of which Dr Siddiqui is now remediated or rather by complacency.

74. With reference to Dr Siddiqui's skills being up to date, Mr Barton highlighted that Dr Siddiqui has not worked since her time at CHEC.

75. Mr Barton invited the Tribunal to consider the three limbs of public protection to determine which are engaged. He submitted that the clear risks to patient safety, the significant and repeated departures from professional standards and the lack of insight warrant a finding of impairment against Dr Siddiqui's fitness to practise.

Submissions on behalf of the Doctor.

76. On behalf of Dr Siddiqui, Ms Vivienne Tanchel submitted that the Guidance does not adequately set out the two-stage process in deciding impairment in the way it was envisaged in multiple cases and jurisprudence across decades. She submitted that the context of the doctor's behaviour must be examined and directed the Tribunal to paragraph 22 in the case of *Cheatle v General Medical Council [2009] EWHC 645 (Admin) (27 March 2009)* which reads:

> *'22 In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct.'*

77. Ms Tanchel submitted that the Doctor's misconduct may also be such that seen within the context of an otherwise unblemished record, her fitness to practice is not impaired. She directed the Tribunal to the case *of Zygmunt, R (on the application of) v General Medical Council [2008] EWHC 2643 (Admin) (10 October 2008)* which states:

> *'31. In a misconduct or deficient performance case, the task of the Panel is to determine whether the fitness to practise is impaired by reason of misconduct or deficient performance. It may well be, especially in circumstances in which the practitioner does acknowledge his deficiencies and take prompt and sufficient steps to remedy them, that there will be cases in which a practitioner is no longer any less fit to practise than colleagues with an unblemished record.'*

78. Ms Tanchel further directed the Tribunal to the case of *General Medical Council v Meadow [2006] EWCA Civ 1390 (26 October 2006)* which states:

> *'32. The purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'*

79. Ms Tanchel submitted that with regards to the clinical allegations (relating to gloves and non-sterile instruments) most of the allegations had been admitted by Dr Siddiqui in the first place. Where they were not, Dr Siddiqui recognises the findings made by the Tribunal. Dr Siddiqui accepted her misconduct with regards to those allegations but maintained her innocence with regards to the probity allegations. However, Dr Siddiqui recognises that this is not the appropriate forum to raise those concerns and does not seek to re-litigate those matters. Dr Siddiqui does not accept impairment based on public safety, noting that her behaviour will never reoccur but recognises how her lapse impacts public confidence and professional standards.

80. Ms Tanchel referred the Tribunal to the case of *Sawati v General Medical Council [2022] EWHC 283* and quoted from paragraphs 75 - 110 of the judgment which provided guidance on the approach a Tribunal should take when considering a rejected defence. In particular, Ms Tanchel reminded the Tribunal, as set out at paragraph 77 of the judgment that a doctor who denies dishonesty before a Tribunal is, *"at risk of being found for that reason to 'be in denial' about, or 'lack insight' into, their fault – and 'difficult to remediate' is converted into 'irremediable'."* Further, the doctor may be found to have compounded the dishonesty by not telling the truth to the Tribunal.

81. Ms Tanchel highlighted the principles derived from the high court case of *Sayer v General Osteopathic Council [2021] EWHC 270 (Admin)* set out at paragraph 94 of the Judgment which provided that:

> *(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.*
> *(2) Denial of misconduct is not a reason to increase sanction.*
> *(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.*

(4) However, attitude to the underlying allegation is properly to be considered when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.

(5) The assessment of the extent of insight is a matter for the Tribunal, weighing all the evidence and having heard the registrant.

82. Ms Tanchel then directed the Tribunal to the conclusions based on the Court's review of relevant caselaw preceding *Sawati*, contained in paragraphs 103-110 of the judgment. Paragraph 109 summarises that, before a Tribunal can be sure of making fair use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself ... that doctors are properly and fairly entitled to defend themselves, and may then find it helpful to think about four things:

(i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all,
(ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge;
(iii) how far 'lack of insight' is evidenced by anything other than the rejected defence and
(iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others' dishonesty.

83. Ms Tanchel asserted, based on a range of case law and jurisprudence that denial of the facts does not ineluctably lead to findings of Impairment or indeed in due course to sanction.

84. With regards to the contaminated gloves, Ms Tanchel accepted that matters were serious. However, with reference to the instruments Ms Tanchel reminded the Tribunal that in his oral evidence, the expert witness offered a more nuanced view where he stated that if certain criteria were met such as neither clinicians nor users being at risk, and with appropriate permission it may then be acceptable to take home unused non-sterile equipment.

85. With regards to other matters, Ms Tanchel submitted that other matters were not at the higher end of the spectrum of seriousness. She directed the Tribunal to paragraph 28 of the guidance which reads:

'Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:

- *clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes…'*

86. Ms Tanchel cautioned the Tribunal against putting the clinical failings at the very serious end of the spectrum because even seriously below the expected standard has a spectrum.

87. With regards to the dishonesty, Ms Tanchel submitted that it was one incident of a limited impact and did not offer the doctor any benefit financial or otherwise. While the incident occurred within the Doctor's professional capacity, the dishonesty was a knee jerk reaction to being confronted by a difficult situation. It was not premediated. Ms Tanchel further highlighted that it was Dr Siddiqui who went to find Ms G to escalate matters in the face of fast moving and distressing circumstances. Hence, Ms Tanchel submitted that this is not the kind of dishonesty that engages the most extreme end of the spectrum of seriousness. She noted that dishonesty too, has a spectrum and Dr Siddiqui's case ought to inhabit the low range.

88. On the matter of Dr Siddiqui's remediation, Ms Tanchel highlighted that Dr Siddiqui has written a reflective statement and undertaken refresher training in infection control and probity. Ms Tanchel noted that the Tribunal had direct evidence of remediation with respect to the collection of non-sterile medical instruments where Dr Siddiqui ceased her collection the instant she was asked to do so.

89. Ms Tanchel further submitted that Dr Siddiqui has no fitness to practice history. Her behaviour was not an abuse of professional position, nor was it predatory or premediated in nature. No patients were harmed as a result of Dr Siddiqui's dishonesty. While patient D was distressed, there is no evidence to suggest that she contracted any kind of infection.

90. Ms Tanchel submitted that it is easy for professionals to become complacent where they engage in repetitive actions. That complacency has been completely eradicated in the case of Dr Siddiqui for she has gone through the process of this fitness to practise proceedings which have had a profound and distressing impact upon her.

The relevant legal principles

91. There is no burden or standard of proof at this stage of the proceedings, and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

92. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

93. To assess whether Dr Siddiqui poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- Where on the spectrum of seriousness the allegation lies, based on the facts found proved; the impact of any relevant context known about Dr Siddiqui and/or their working environment; and
- how Dr Siddiqui has responded to the allegations.

The Tribunal's determination on impairment

Is there a legal basis for considering impairment?

94. The Tribunal considered that Dr Siddiqui's examination of 3 patients while wearing gloves contaminated with blood belonging to other patients were fundamental and serious breaches of Good Medical Practice that affects all three limbs of public protection and seriously violates infection control standards. This constituted misconduct going to fitness to practice at the first stage of the impairment test. In coming to this conclusion, the Tribunal considered the evidence of Mr K about the standards expected of a consultant ophthalmologist and noted that Dr Siddiqui had over 30 years of experience in Ophthalmology and hence, should have been aware of the importance of hand hygiene practices and the serious risks of harm to patients in failing to observe the same.

95. The Tribunal were not persuaded by Ms Tanchel's assertion that the lack of harm to Patient D detracted from the gravity of the conduct, noting that the threat of blood-borne infection to Patient D was very real and she was clearly distressed by the incident and had to wait 3 months before testing could rule out contraction of disease. For all patients, the breach of hand hygiene procedure holds potentially life-altering consequences.

96. The Tribunal considered that the harm was not restricted to public safety but further threatened professional standards and public confidence in the medical profession.

97. The Tribunal, informed by the expert opinion of Mr K, found that the collection of used medical instruments amounted to misconduct going to fitness to practice.

98. The finding that Dr Siddiqui had remarked that the incident with Patient D was an isolated incident when she knew that was untrue was dishonest. The Tribunal considered that this was a serious departure from the standard to be expected of a doctor. Therefore, this amounted to misconduct going to fitness to practice.

Use of blood-stained gloves

Where on the spectrum of seriousness do the allegations lie?

99. The Tribunal considered paragraph 31 of the guidance which reads:

'Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:

…

clinical failings that are not considered to be easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients.

100. Informed by Mr K's expert evidence, the Tribunal were of the view that the examination of 3 patients with gloves stained with blood belonging to other patients amounted to gross negligence and recklessness relating to the risk of serious harm to patients. The fact that there were more than 1 such instances of the conduct meant that the starting point for assessing risk to public protection was high on the spectrum of seriousness.

What is the impact of any relevant context known about Dr Siddiqui and/or their working environment?

101. The Tribunal acknowledged that Dr Siddiqui worked in a busy clinic where patients were triaged indirectly into an operating theatre without a prior pre-operative consultation. This placed additional responsibilities of diagnosis on Dr Siddiqui and increased her workload. They considered the evidence of Ms G who also acknowledged that the minor operations list on 10 December 2024 was extremely busy. The Tribunal were mindful of paragraph 55 of the guidance which reads:

'55. The MPT may have information available to them about systems factors or interpersonal factors that are outside a doctor's control, and which had an impact on their behaviour, performance, or health at the time. Where this is the case, the relevant

context may decrease the level of current and ongoing risk the doctor poses to one or more of the three parts of public protection where the likelihood of repetition has been removed or reduced, either because the working environment itself has now changed or because steps have been put in place to mitigate the impact on the doctor. This may include where there is evidence to show that workload issues, challenges with technologies or problems caused by poor team or organisational culture have now been addressed, or where the doctor has improved support or supervision arrangements.'

102. The Tribunal further considered paragraph 59 which states:

'59. In cases where there is evidence of working environment context that may decrease risk, this will usually have less impact, and therefore carry less weight, where the allegation falls at the higher end of the spectrum of seriousness. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.'

103. The Tribunal noted that the working environment of a doctor in the current climate can often be busy and pressured. As Dr Siddiqui was not currently working, there was no evidence that her working environment, if she returned to ophthalmology, would be changed. There was no evidence that any steps outside Dr Siddiqui's personal control had been implemented to mitigate the impact of a busy list on Dr Siddiqui. Therefore, the context of Dr Siddiqui's working environment did not reduce the seriousness of level of risk posed to public protection by her misconduct.

104. The Tribunal considered the fact that Dr Siddiqui held the post of Consultant and was in a leadership position. The Tribunal considered that a doctor in a senior or leading role is more likely to be capable of influencing others and having an impact on workplace culture. Therefore, where Dr Siddiqui demonstrated repeated departure from the professional standards expected, this had an additional impact on the level of risk to public protection, increasing the same.

<u>How has Dr Siddiqui responded to the allegations?</u>

105. The Tribunal noted that Dr Siddiqui made full admissions with regards to Patient B and Patient D. Her justification for not doing the same with Patient A was that she could not recall the incident. She was entitled to put the GMC to proof. She tested the evidence of Ms J, Ms G and Ms F without suggesting that they were deliberately lying. There was nothing about her defence to the allegation in relation to Patient A which should be held against her in terms of the risk of public protection. Whilst the Tribunal had concerns at the facts stage as to Dr Siddiqui's denial of conversations recounted by the GMC's witnesses, the Tribunal did not feel it just, when

balancing the importance of a fair trial to the doctor, to treat her defence as a factor which increased the seriousness of the harm posed to any of the 3 limbs of public protection.

106. The Tribunal acknowledged that Dr Siddiqui immediately apologised to Patient D and requested the opportunity for a meeting with the patient the following day to further apologise. This is important evidence of empathy and insight into the gravity of her behaviour. This was given significant weight by the Tribunal. Furthermore, Dr Siddiqui has expressed what the Tribunal find to be genuine remorse in her reflective statement and in the oral evidence given to the Tribunal at the facts stage. She is cognisant about the impact of her actions on the patients, her working colleagues as well as the broader profession. Whilst these factors decreased the seriousness of the risk of harm posed to patient safety and public confidence, the Tribunal determined that the risk was still high.

107. The Tribunal noted paragraphs 108 and 109 of the Guidance and were of the view that the misconduct was remediable, notwithstanding that similar conduct can be difficult to remediate where it had the potential to damage public confidence in the profession. They placed substantial weight on the actions taken by Dr Siddiqui in undertaking online courses in Infection Prevention and Control, completed in 2026 and her reflective statement outlining her insight into the importance of future compliance. However, it was recognised that Dr Siddiqui has not had a chance to demonstrate her remediation as she has not worked since her time at CHEC. Given the caveat above, that the conduct can be difficult to remediate where it is capable of damaging public confidence, the Tribunal felt that the public would want further reassurance of remediation in practice. Whilst evidence of some remediation decreased the seriousness of the risk of harm posed to patient safety and public confidence, the Tribunal determined that the risk was still high.

108. The Tribunal noted the impression that the GMC's investigation and the MPT process has had on Dr Siddiqui, accepting their impact as highlighted by Ms Tanchel. Overall, whilst the Tribunal did not agree that the same conduct would *never* happen, particularly given the events in December 2024 that followed the departures from appropriate practice in August 2024, the Tribunal felt that further repetition of the behaviour was unlikely. Therefore, there was a low but nonetheless real risk of repetition which was significant due to the importance of infection control and the harm that can arise where hand hygiene measures are breached. Hence, the Tribunal concluded that the risk to patient safety was medium. However, the risk to the maintenance of professional standards and public confidence was high.

<u>Tribunal's decision as to whether Dr Siddiqui poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment</u>

109. The Tribunal concluded that, in relation to Dr Siddiqui's misconduct in using blood-stained gloves to examine other patients, there is an ongoing and present risk to all 3 areas of public protection. The level of risk is high. This is because whilst repetition is unlikely the potential harm in the event of repetition is serious, the risk of spreading infection, bloodborne viruses and pathogens have a potentially devastating impact on a patient. Moreover, the effect upon professional standards by any repetition has the potential to be very serious given Dr Siddiqui is in a senior role; repetition could trigger more widespread complacency or departure from infection control measures. The risk to public confidence in the profession is such that the evidence of insight and remediation, whilst of good quality, cannot fully address the risk to public confidence due in part to the nature of the misconduct and the fact that Dr Siddiqui has not been exposed to a similar working environment since leaving CHEC to prove the efficacy of her remediation to-date.

Medical Instruments

Where on the spectrum of seriousness does the allegation lie?

110. The Tribunal considered that the allegation fell at a low level of the spectrum of seriousness. Factors considered were:

(a) that Dr Siddiqui was collecting the instruments for charitable causes;
(b) Dr Siddiqui understood that the receiving party for the medical instruments had appropriate sterilisation means to safeguard patients upon whom those instruments might be used.
(c) Dr Siddiqui's collection of the instruments was done transparently.

111. The fact that Dr Siddiqui was acting in a Consultant role, one of seniority and leadership at the relevant time, did increase the seriousness of the allegation. However, there were no further features that increased the seriousness of the allegation.

What is the impact of any relevant context known about Dr Siddiqui and/or their working environment?

112. Dr Siddiqui had collected medical equipment for charity from other institutions before and believed that her practice in doing so was for a good cause and posed no harm. She did not gain financially; her motives were entirely altruistic. These factors reduced the level of seriousness

How has Dr Siddiqui responded to the allegations?

113. When Dr Siddiqui was asked to stop collecting used medical instruments in August 2024, she did so immediately. There was no repetition after that whilst she remained in post at CHEC. The conduct was remediable with understanding of local infection control practices and relevant legislation which Dr Siddiqui acknowledged it was her responsibility to consult and inform herself about. She has demonstrated insight in her reflective statement which, in the Tribunal's view, reduces still further the level of seriousness.

Tribunal's decision as to whether Dr Siddiqui poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

114. The Tribunal considered that there was no current and ongoing risk to any of the 3 aspects of public protection arising out of Dr Siddiqui's collection of non-sterile medical instruments due to the context of the conduct, the same being for charitable causes; the absence of repetition over a 4 month period following Dr Siddiqui's warning that she was not to continue those collections; and the insight demonstrated by Dr Siddiqui into the importance of seeking out and adhering to the infection control policies designed for patient safety.

Dishonesty

Where on the spectrum of seriousness do the allegations lie?

115. The Tribunal considered paragraphs 80 and 81 of the Guidance Introduction which emphasises that good doctors are open and honest with patients if things have gone wrong and must respond honestly to complaints and apologise appropriately. Further, Good Medical Practice requires doctors to be honest, trustworthy and act with integrity.

116. The Tribunal considered that their finding of fact pertained to a single incident, committed in the heat of the moment as a knee-jerk reaction. Further, the Tribunal found that whilst Dr Siddiqui's initial impulse was to minimise the nature of the incident involving Patient D, her response to the allegation in the course of these fitness to practice proceedings was a full admission and she had sought to apologise to Patient D soon after the event.

117. However, as the incident arose during Dr Siddiqui's professional practice it posed a breakdown of trust and undermined public confidence. The Tribunal did not identify a risk to

patient safety or professional standards. The Tribunal felt that the starting point was the allegation fell within the mid-range of the spectrum of seriousness.

118. It was relevant that the instance of dishonesty was not premediated. There was however the risk that the dishonesty undermined Dr Siddiqui's collaborative working with Ms G. In practice, having heard from Ms G who continued to speak highly of Dr Siddiqui, the impact on their working relationship had been limited and so this issue did not increase the seriousness of the allegation fell in the mid-range of the spectrum of seriousness.

What is the impact of any relevant context known about Dr Siddiqui and/or their working environment?

119. There were matters of context which mitigated the seriousness of the dishonesty. The words were said in the heat of the moment and had little effect on the overall conduct of the investigation into the incident with Patient D. Dr Siddiqui was no doubt shocked and distressed at Patient D's reaction to the events. It was the evidence of Ms G that, at the relevant time, Dr Siddiqui appeared to be upset.

120. There were matters of context which aggravated the dishonesty. The Tribunal noted paragraph 57 of the Guidance which highlights that, to comply with their professional duty of candour, all medical professionals are expected to raise and act on concerns about patient safety. Where a doctor failed to take reasonable steps to raise concerns about patient safety, this may increase the level of current and ongoing risk the doctor poses to public protection because of the potential risk to patient safety. The Tribunal found that Dr Siddiqui must have recalled the breaches of appropriate hand hygiene in August 2024 when confronted with the same issue in December 2024. Describing the latter as an isolated incident was inaccurate and minimised what ought to have been a declared concern about patient safety. Dr Siddiqui ought to have recognised that this 3rd instance of poor infection control suggested a real risk to patient safety and she ought to have raised this in line with her duty of candour rather than minimising it. This increased the seriousness of the allegation.

How has Dr Siddiqui responded to the allegations?

121. Dr Siddiqui continues to deny any dishonesty, which is her right so to do. It was relevant, in the Tribunal's view that Dr Siddiqui's defence centred on her subjective intention behind the words "isolated incident" if she said them at all, rather than alleging that Ms G was being untruthful in her recollection. That said, the Tribunal had, at the facts stage, been

concerned by Dr Siddiqui's absence of recollection of other ancillary conversations said to have taken place and transcribed in contemporaneous documents.

122. Notwithstanding that she does not consider herself to have been dishonest, in October 2026 Dr Siddiqui did undertake a course looking at the significance of probity issues for doctors which aimed to raise awareness of potential behaviour that might lead to dishonesty in a personal and professional setting. There was some limited evidence of insight and remediation. However, in the Tribunal's view this was not sufficient to reduce the risk from medium.

Tribunal's decision as to whether Dr Siddiqui poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

123. The Tribunal found that there was a current and ongoing medium risk posed by Dr Siddiqui's dishonesty to patient safety and public confidence. The dishonesty, whilst committed as a knee-jerk reaction and without premeditation, was likely to undermine public confidence in the profession because it contravened the fundamental requirement of doctors to act with honesty and integrity. There had been some remediation and insight demonstrated but that was of insufficient quality to adequately address the risks to public protection identified.

124. The Tribunal has therefore determined that Dr Siddiqui's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 03/11/2026

125. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

The evidence

126. The Tribunal has reviewed its findings at the facts and impairment stages and took into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions on behalf of the GMC

127. On behalf of the GMC, Mr Hugh Barton directed the Tribunal to the relevant parts of the guidance on sanction as well as the specific sanction banding guidance on dishonesty.

128. Mr Barton noted that as a part of their stage two determination, the Tribunal had identified a high risk to all three limbs of public protection with regards to the contaminated gloves. Mr Barton submitted that the relevant banding for clinical concerns of the kind ranges from a 6-month Suspension to Erasure.

129. On the matter of dishonesty, Mr Barton acknowledged that the Tribunal had found a medium risk to patient safety and public confidence. He submitted that the relevant banding for the same is a Suspension ranging from 3-9 months. He further noted that the Tribunal had found no current or future risk to public protection regarding the used medical instruments.

130. Mr Barton reminded the Tribunal that they have the option of taking no action in exceptional circumstances. However he added that to take no action in this case would be inconsistent with the Tribunal's findings made at stage two.

131. With regards to Conditions, Mr Barton directed the Tribunal to paragraphs 17 and 20 of the guidance which read:

> *'17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future.'*
> …
> *'20. Where Conditions are put in place, they should be appropriate, workable, and measurable.'*

132. Mr Barton submitted that it is difficult to see how Conditions would be workable or measurable in relation to a dishonesty concern. He highlighted that the sanctions banding for dishonesty does not allow for Conditions even for matters of low risk. Mr Barton further directed the Tribunal to paragraph 30 of the guidance which states:

> *'Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of the spectrum of seriousness and/or suggest an underlying problem with their attitude.'*

133. Hence, Mr Barton submitted that Conditions would not be workable nor be consistent with the Tribunal's assessment of risk in relation to the clinical concerns.

134. With regards to Suspension, Mr Barton directed the Tribunal to paragraphs 41 and 45 of the guidance that state:

> *'41. Suspension is for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period, with the aim they should be able to safely return to unrestricted practice in the future.'*
> …
> *'45. Suspension may be proportionate in cases where some, or all, of the following factors are present:*
> *a. Conditions are not appropriate, measurable and/or workable*
> *b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with Conditions and Suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
> *c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, Suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

135. Mr Barton submitted that bearing in mind Conditions are not appropriate for the case, a Suspension would be proportionate and commensurate to the level of risk that the Tribunal has identified in this case.

136. For the duration of the Suspension, Mr Barton added that he does not seek to persuade the Tribunal to go beyond the range identified within the relevant bandings. He reminded the Tribunal that the bottom of the clinical concerns with high risk to public protection band directs a Suspension of 6 months.

137. With regards to a Review, Mr Barton directed the Tribunal to paragraph 52 of the guidance and asserted that a Review is necessary and would be consistent with stage two findings. Paragraph 52 reads:

'The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of Suspension concludes and so a review should be directed. The exception to this is where a short Suspension (usually three months or less) has been imposed on public confidence grounds and/or to maintain professional standards. '

138. On Erasure, Mr Barton submitted that it would be above the banding for even the highest level of dishonesty. Erasure is reserved for the most serious instances of clinical concern and would not be necessary if the Tribunal finds Suspension sufficient to protect the public.

Submissions on behalf of the Doctor

139. On behalf of Dr Siddiqui, Ms Vivian Tanchel reminded the Tribunal of their findings at stage two, noting that the misconduct was remediable and placing weight on the fact that Dr Siddiqui had completed online courses.

140. Ms Tanchel observed that the Tribunal had concluded that the risk of repetition regarding the contaminated gloves allegation was low but posed a serious risk to public protection if ever repeated. Ms Tanchel submitted that this nuance is not accounted for in the guidance nor in the submissions made by the GMC. She reminded the Tribunal that it must not punish Dr Siddiqui but focus on protecting the public. Hence, Ms Tanchel asserted that as the risk of repetition has been found unlikely at stage two, this clinical finding of impairment does not fall within the sanctions banding reiterated to the Tribunal by the GMC.

141. Ms Tanchel highlighted that the Tribunal had previously found the evidence of insight and remediation to be of good quality, but incapable of fully addressing the risk to public confidence due to the nature of the misconduct and the fact that Dr Siddiqui has not been exposed to a similar working environment since leaving CHEC.

142. With regards to Conditions, Ms Tanchel submitted that they are not appropriate in this case. She further noted that for a doctor at Dr Siddiqui's level of seniority, Conditions may be paramount to Suspension for they are difficult to implement.

143. With regards to a Suspension, Ms Tanchel submitted that considering the circumstances of the case, the Suspension should be shorter than 3 months. She reminded the Tribunal that the risk of repetition for the use of blood-stained gloves was low and warranted a shorter Suspension between one and three months.

144. On the matter of a Review, Ms Tanchel submitted that it is 'lazy' for the GMC to often ask for a Review, which puts a great deal of responsibility on the Tribunal to assess risk as a fact. She asserted that it was unclear what new information would be available to the Tribunal if it was to direct a Review.

145. Ms Tanchel highlighted that Dr Siddiqui is a woman in her XXX and has been practicing for decades. The breach was serious but limited to those 3 patients on 2 different dates. Dr Siddiqui has had a career otherwise unblemished by any fitness to practise history. She is also well respected by her colleagues, as was made evident over the course of witness evidence.

146. Ms Tanchel submitted that a short Suspension without a review would protect the reputation of the profession. Every member of the public, including Dr Siddiqui's fellow clinicians, will be satisfied that the GMC and the Medical Practitioners Tribunal Service has discharged its statutory function by making plain that they believe that the conduct engaged in by Dr. Siddiqui was simply unacceptable. Ms Tanchel further noted that if suspended, Dr Siddiqui would not be able to work. Hence, a review would not help mitigate an ongoing concern.

147. As per Ms Tanchel's submission, what does mitigate an ongoing concern is Dr Siddiqui's unequivocal engagement with the proceedings and her remorse, regret and understanding of what has gone wrong. The prime focus is to ensure that she embeds that into her own thinking, and the public is satisfied that the regulator and the Tribunal have taken all appropriate steps.

148. Ms Tanchel drew the Tribunal's attention to the case *of Giele v General Medical Council [2005] EWHC 2143 (Admin) (14 October 2005)* which discusses the public interest in allowing a registrant to return to practice. She submitted that there is a public interest in ensuring that the skills of an ophthalmologist are available to citizens of this country.

The Tribunal's determination on sanction

149. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. It has referred to the sanctions banding for dishonesty as set out in Part C of the Guidance for MPT Hearings. It has also considered the impact of any specific sanction type on Dr Siddiqui and the testimonials provided.

No Action

150. In reaching its decision as to the appropriate sanction, if any, to impose in this case, the Tribunal first considered whether to take no action. Given the findings against Dr Siddiqui of using blood-stained gloves on patients and being dishonest which poses an ongoing risk to public protection, the Tribunal considered that taking no action would fail to maintain public safety and public confidence, nor would it serve to uphold professional standards. They remained cognisant of the fact that no undertakings had been agreed on between the parties.

Conditions

151. The Tribunal noted that counsel agreed that for the Tribunal to impose Conditions would be inappropriate. The Tribunal accepted Ms Tanchel's submission that, given Dr Siddiqui's seniority, implementing Conditions may be unworkable and hence paramount to Suspension if Dr Siddiqui cannot find employment as a locum consultant. It reminded itself of paragraph 20 and 30 of the guidance which read:

'Where Conditions are put in place, they should be appropriate, workable, and measurable.'

…

'Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of the spectrum of seriousness and/or suggest an underlying problem with their attitude.'

152. The Tribunal reminded itself that they must consider the least punitive sanction with the aim of protecting the public and not punishing the Doctor. The Tribunal reflected that if regular Conditions were workable, supervision of Dr Siddiqui's adherence to hand hygiene in the workplace for a period would have allowed her to develop and demonstrate consistency in this important aspect of infection control with support, addressing the risk to patient safety very well. The Tribunal were mindful that Conditions, whilst addressing patient safety, may be regarded as disproportionate to the seriousness of the case, where 3 patients were involved and there was an instance of dishonesty. Thus, Conditions were likely to be insufficient and would not send a clear message to other members of the profession in the interest of upholding professional standards. Similarly, Conditions would not reflect the seriousness of the failure which put patients at risk. Further, accepting counsel's submission that Conditions are difficult to implement for a doctor of Dr Siddiqui's seniority, the Tribunal went on to consider Suspension.

Suspension

153. The Tribunal noted that counsel agreed that a period of Suspension was proportionate having reviewed the Tribunal's determination on impairment. The Tribunal considered Ms Tanchel's submission that the low risk of repetition of the hand hygiene issue identified by the Tribunal at stage 2 should move the Tribunal's risk assessment on sanction. However, the Tribunal was of the mind that the unlikelihood of repetition did not alleviate the harmful risk to public confidence and professional standards. Moreover, the nature of the risk of harm to patients if the conduct was to reoccur was extremely serious. Further, the logic of Ms Tanchel's submission disregarded the Tribunal's findings at stage 2 on dishonesty.

154. The Tribunal considered the guidance on sanction. A Suspension of 6 months to Erasure is the sanction range for a high-risk clinical concerns case. The sanction for dishonesty where there is medium level of risk to public protection is Suspension between 3-9 months. Hence, the Tribunal were of the view that the sanction banding in this case was from a 6-month Suspension to Erasure.

155. The Tribunal considered that Dr Siddiqui is a senior doctor, who is well respected by her colleagues and has had an otherwise unblemished career. It was also of the view that the infection control incidents were the product of complacency and can be remediated by practicing proper hand hygiene.

156. The Tribunal remained cognisant of the public interest of having the Doctor return to work. They noted that a prolonged period of Suspension may result in Dr Siddiqui retiring or else finding re-entry to work very difficult. However, the interests of Dr Siddiqui were given less weight than the need to protect the public. The Tribunal agreed that Dr Siddiqui should return to work when the risk to the public has been lowered by her further insight and remediation. They determined that a period of Suspension, at the lower end of the identified range, would balance the interests of Dr Siddiqui and the benefit she can give to the public as an excellent ophthalmologist with the need to send a deterrent message to other members of the profession to uphold professional standards and to reassure the public that repeated lapses in hygiene standards and dishonesty would not be tolerated in the medical profession, thereby maintaining their confidence.

157. Bearing in mind the relevant contextual factors, the Tribunal was of the view that a 6-month Suspension was appropriate and proportionate. Any greater length would be unnecessary and potentially punitive. A Suspension of less than 6 months would not protect the public.

Erasure

158. The Tribunal considered the circumstances of the case and found that Erasure would be both punitive and disproportionate. It would allow no opportunity for Dr Siddiqui to return to work in the near future, which goes against public interest in maintaining within the profession talented and empathic doctors who can, in due course, safely return to unrestricted practice. Hence, it concluded that Erasure was inappropriate.

Review

159. On the matter of a review, the Tribunal felt this could serve a useful purpose. Conditions, had they been proportionate and workable, would have allowed Dr Siddiqui to be supported through a supervised period of work, keeping the importance of infection control at the forefront of her mind, after a lengthy period of absence. This was of particular concern where complacency had been sited as a possible explanation for the 3 instances of hand hygiene lapses. A Review before Dr Siddiqui returns to practice will ensure that the importance of infection control is at the forefront of her mind.

160. The Tribunal therefore directed a review of Dr Siddiqui's case. A review hearing will convene shortly before the end of the period of Suspension of 6 months. The Tribunal wishes to clarify that at the review hearing; the onus will be on Dr Siddiqui to demonstrate how she has remediated. It therefore may assist the reviewing Tribunal if Dr Siddiqui provides evidence about how she has kept her skills up to date and engaged in further remediation in terms of infection control practices. Dr Siddiqui will also be able to provide any other information that she considers will assist the Review panel.

Determination on Immediate Order - 03/11/2026

161. This determination was handed down in public. However, the Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

162. Having determined to suspend Dr Siddiqui from the medical register for a period of 6 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Siddiqui's registration should be subject to an immediate order.

Submissions

163. On behalf of the GMC, Mr Hugh Barton directed the Tribunal to the relevant parts of the Guidance including paragraph 79 and 83. They state:

> *'79. The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.'*
> …
> *'83. The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.'*

164. In accordance with paragraph 84, Mr Barton invited the Tribunal to impose an immediate order. Paragraph 84 states:

> *'It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
> *a. the doctor poses a risk to patient safety*
> *b. the risk to one or more parts of public protection is high, and/or*
> *c. immediate action is needed to maintain public confidence in the medical profession.'*

165. On behalf of Dr Siddiqui, Ms Vivian Tanchel opposed an immediate order. She submitted that the public interest is well served by the determinations made during the case. The determinations shall be published on the MPTS website and hence no member of the public shall be left unaware that a sanction has been imposed on Dr Siddiqui's practice.

166. With regards to the clinical risk with the use of contaminated gloves, Ms Tanchel reiterated her previous submission at the sanction stage and noted that the Tribunal was not convinced that the unlikelihood of repetition moves the overall risk from high to medium. However, she asserted that this feature ought to be at the forefront of the Tribunal's mind in balancing whether an immediate order is proportionate and necessary. She submitted that having a sanction ordered, published and subject to an upcoming review shall further lower the risk of recurrence.

167. Ms Tanchel opposed the GMC's submission that the immediate order would be in Dr Siddiqui's interest. She submitted that what is in the doctor's interest is entirely a matter for the doctor in the given circumstances.

The Tribunal's approach

168. The Tribunal were reminded by the Legally Qualified Chair that the Tribunal's power to make an Immediate Order is derived from Section 38 of the Medical Act 1983 (as amended) which provides that an order for suspension can be made forthwith where The Tribunal is satisfied that to do so is necessary for the protection of members of the public or is otherwise in the public interest, or is in the best interests of the doctor.

169. Paragraph 84 of the Sanctions Guidance was highlighted as set out by Mr Barton in his submissions.

The Tribunal's determination

170. The Tribunal understood why Mr Barton had anticipated that an immediate order would be in Dr Siddiqui's best interests since it would make the period in which she was suspended from practice shorter than otherwise, since the sanction would take effect in 28 days without that order. However, the Tribunal noted Ms Tanchel's submission, that it was not in Dr Siddiqui's bests interests for the Tribunal to make an immediate order. The Tribunal therefore considered paragraph 81 of the sanctions guidance which guided them to give consideration to the interests of the doctor which may, for example, be to return to work pending the outcome of any appeal and to balance that preference against the wider public interest.

171. The Tribunal considered paragraphs 83 and 84 of the guidance and reminded themselves that they had identified a risk to public safety at the earlier stages of the hearing. It was necessary to consider the seriousness of the proved allegation. The Tribunal reminded itself that at the impairment stage, they had balanced the low but real risk of repetition of Dr Siddiqui's departures from hand hygiene protocol with the potentially serious impact of such a departure on patient safety and concluded, in paragraph 48 of their determination, that the risk to patient safety was medium. A low probability event can nevertheless represent a significant risk where the potential consequences are sufficiently serious. Risk is not assessed solely by the likelihood of an event occurring, but also by the severity of the harm that would result if it did occur.

172. Importantly, the Tribunal had also determined that, notwithstanding that repetition was on the balance of probabilities unlikely, the risk to the maintenance of professional standards and public confidence was high. Therefore in paragraph 49 of the determination, the Tribunal concluded that overall, taking the medium risk to patient safety alongside the high risk to public confidence and professional standard, the overall characterisation of the risk to all 3 limbs of public protection was high. The Tribunal concluded that this aspect of the proved allegation was to be regarded as serious within the meaning imputed by paragraph 83 of the Sanctions Guidance.

173. The Tribunal turned to consider the seriousness of the other aspect of the allegation, that is the dishonesty allegation. In their determination, the Tribunal concluded that there was risk to both patient safety and public confidence posed by the allegations. As highlighted by Ms Tanchel during submissions on sanction, the Tribunal, in paragraph 55 of their written determination, did not identify a risk to patient safety. It was clarified in open session that this was an error and whilst the Tribunal had not initially identified a risk to patient safety, after consulting the Guidance, that risk was identified. This appears at paragraph 58 of the determination which references paragraph 57 of the Guidance which highlights that, *Where a doctor failed to take reasonable steps to raise concerns about patient safety, this may increase the level of current and ongoing risk the doctor poses to public protection because of the potential risk to patient safety.*

174. At stage 2, the Tribunal had identified a medium level of seriousness and determined that there was a medium risk to patient safety and public confidence in the medical profession by reason of the proven allegation of dishonesty.

175. The Tribunal then reminded itself of its determination on sanction. The Tribunal had found that a 6-month suspension would balance the interests of Dr Siddiqui and the benefit she can give to the public as a senior and skilled ophthalmologist with the need to send a deterrent message to other members of the profession to uphold professional standards and to reassure the public that repeated lapses in hygiene standards and dishonesty are not acceptable in the medical profession, thereby maintaining their confidence.

176. The Tribunal considered Ms Tanchel's submission that the patient safety concerns were addressed by reason of these proceedings being fresh in Dr Siddiqui's mind and the public interest is served by the determination being published on the MPTS website. The Tribunal reflected that the outcome of the decision will be available on the Tribunal website shortly, despite there being up to 28 days for the detailed reasons to be published. There was some force in Ms Tanchel's submission and the Tribunal reflected upon this with care. However, the Tribunal remained concerned after deliberation that the public and other members of the

medical profession would be concerned to think that, notwithstanding the Tribunal's imposition of a sanction, Dr Siddiqui may be able to return to work immediately and for the duration of any appeal. That would not adequately protect public confidence in the medical profession, nor maintain public standards.

177. Therefore, in light of the identified risks to the public; the seriousness of the proven allegations, and the Tribunal's reasoning for imposing the sanction it has, the Tribunal were of the view that it would be inconsistent with previous findings to not impose an immediate order. An immediate order was felt necessary to protect the public.

178. Hence, the Tribunal determined to impose an immediate order of suspension on Dr Siddiqui's medical registration.

179. This means that Dr Siddiqui's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

180. The interim order currently in place on Dr Siddiqui's registration is hereby revoked.

ANNEX A – 28/10/2026

Application to adduce evidence under Rule 34 (1)

181. During the cross examination of Dr Siddiqui, Mr Hugh Barton on behalf of the GMC made an application for an alternate version of Dr Siddiqui's Curriculum Vitae (CV) to be adduced into evidence pursuant to Rule 34(1) of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules).

Submissions on behalf of the GMC

182. Mr Barton submitted that, as a result of Dr Siddiqui's answers to his questions under cross-examination, he wished to explore the differences between two different CV's belonging to Dr Siddiqui. The detail in the alternate CV was relevant to a matter, which in his option, was critical to determining the credibility of the witness.

183. Mr Barton reminded the Tribunal that their discretion to admit evidence is governed by Rule 34(1) of the Rules, which states that the Tribunal may admit any evidence they consider fair and relevant to the case before them.

184. Mr Barton urged the Tribunal to consider the fairness of the proceedings. He further noted that even though the witness had not been prepared to answer questions on this document, it was a document of her own creation and had been submitted to the GMC by Dr Siddiqui at an earlier date.

Submissions on behalf of Dr Siddiqui

185. On behalf of Dr Siddiqui, Ms Tanchel opposed the application.

186. Ms Tanchel submitted that while Rule 34 allows for the admission of further evidence, there is wider jurisprudence on how to deal with previous inconsistent statements.

187. Ms Tanchel reminded the Tribunal that the Rules require the GMC to disclose its case in an appropriate and timely manner. An application to adduce evidence at this stage must either be in response to an inconsistency in the evidence or that matters have arisen that the GMC was not previously aware of. She submitted that Mr Barton had not established an inconsistency in the evidence before the Tribunal.

188. Ms Tanchel submitted that the GMC had the opportunity to put any documents they chose into the bundle. The GMC was given a copy of the CV that they now wished to be admitted into evidence in 2025 and have since had it in their possession. In answers to Tribunal's questions, Ms Tanchel conceded that the alternate CV may hold potential relevance to matters upon which Mr Barton had just cross-examined Dr Siddiqui.

The Tribunal's Determination

189. The Tribunal considered the test for admitting evidence in hearings, as set out in Rule 34(1):

> *'The Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law'.*

190. The Tribunal found the document to be relevant based on counsels' submissions and noted that Dr Siddiqui's credibility is a key matter to determine, particularly in relation to an alleged meeting between her and Mr H, which was at the centre of allegation 10(c)(ii).

191. In terms of fairness, the Tribunal was cautious of the fact that Dr Siddiqui had not prepared to answer questions on this version of her CV as it was not in the bundle. However the Tribunal reminded itself that prior to the commencement of Dr Siddiqui's evidence, it had acceded to an (unopposed) application to adduce evidence made on her behalf, in the form of a CV. The evidence in question was another CV that was provided to Mr H as a part of Dr Siddiqui's application to CHEC. The Tribunal, in granting Dr Siddiqui's application, had accepted that the CV she wished to adduce was relevant to understanding her training, qualification and charity work. Therefore, it could not be said that another version of her CV was irrelevant, nor would it be fair to exclude the evidence having just allowed another version of the same type of document into evidence late and after closure of the GMC's case. Weighing all these factors together, the Tribunal deemed it fair to grant the application to admit the document into evidence under Rule 34(1).