

Evidentiary Gaps in Facial Surgery Negligence Litigation: The Role of Photographic Documentation under Indian Medical Law

Sanya Shetty

5th Year BA LLB Student, Thakur Ramnarayan College of Law, S.V Road, Dahisar (East), Mumbai – 400 068

Abstract- Medical negligence claims arising from cosmetic and reconstructive facial surgery in India present distinct evidentiary challenges, particularly in proving deviation from the accepted standard of care. This paper examines whether the absence of pre and post operative photographic documentation creates structural evidentiary barriers for patients in facial surgery negligence claims within the framework of the Consumer Protection Act, 2019, and Section 63 of the Bharatiya Sakshiya Adhinyam, 2023. Through doctrinal analysis of consumer forum and Supreme Court decisions applying the Bolam test as received in *Jacob Mathew v. State of Punjab* (2005), the paper demonstrates how absent photographic documentation weakens complainants' ability to establish negligence. It argues that inconsistent digital record-keeping in healthcare institutions creates structural evidentiary disadvantages for patients and proposes regulatory reforms, including mandatory photographic documentation protocols under National Medical Commission guidelines.

Keywords: Medical negligence, Facial surgery, Clinical photography, Consumer Protection Act 2019, Bharatiya Sakshiya Adhinyam 2023, Evidentiary asymmetry, NMC guidelines

I. INTRODUCTION

Consider the following composite illustration, drawn from patterns observable in reported consumer forum decisions. In 2021, a thirty-four year old schoolteacher from Pune referred to here as Ms. R underwent a rhinoplasty procedure at a private cosmetic clinic in the city. Dissatisfied with the outcome, which she contended had caused permanent nasal asymmetry and partial airway obstruction, Ms. R filed a complaint before the Maharashtra State Consumer Disputes

Redressal Commission alleging deficiency in service and medical negligence on the part of the operating surgeon. The Commission confronted a fundamental evidential void: neither the clinic nor the surgeon had retained any pre-operative or post-operative photographic records. The surgeon's clinical notes, consisting of handwritten observations in a non-standardised format, described the pre-operative nasal anatomy in broad and subjective terms. Without a visual baseline against which to measure the alleged deviation, the Commission's appointed medical expert was unable to offer a substantive opinion on whether the surgical result represented a departure from the standard of care ordinarily expected of a competent rhinoplasty surgeon. Ms. R's complaint was ultimately dismissed, not on the merits of the surgical outcome, but on the insufficiency of the evidentiary record.

While the foregoing is a composite illustration rather than a single adjudicated case, it faithfully reflects a structural problem that recurs across facial surgery negligence litigation in India. The challenge is not one of legal doctrine in isolation, nor of clinical competence in isolation, but of the intersection between the two: a category of surgical procedures whose outcomes are irreducibly visual in character is being adjudicated within an evidentiary framework that does not require the very documentation most probative of the outcome. Facial procedures like rhinoplasty, rhytidectomy, blepharoplasty, post-trauma or oncological reconstruction, and facial liposuction produce harms that are spatial and visible: asymmetry, scarring, distortion of anatomical structures, and loss of natural contour. Unlike physiological harms that may be documented through

laboratory values, imaging reports, or standardised clinical indices, these adverse outcomes are pre-eminently visual phenomena. The most direct, objective, and reproducible means of capturing them is clinical photography.¹

Yet Indian healthcare practice imposes no uniform mandatory requirement for pre- and post-operative photographic documentation in cosmetic or reconstructive facial surgery. The National Medical Commission (*hereinafter* NMC) has not issued binding guidelines mandating photographic documentation as a component of the standard of care in this category of procedures.² The Clinical Establishments (Registration and Regulation) Act, 2010, likewise prescribes no photography requirement.³ The result is a fragmented and discretionary practice: some private hospitals maintain detailed photographic records; many clinics, particularly at the secondary and tertiary levels in smaller urban and semi-urban settings, do not.

This inconsistency has direct legal consequences. Within the adjudicative framework of the Consumer

Protection Act, 2019 (*hereinafter* CPA 2019),⁴ where the preponderance of medical negligence claims in India are litigated, the burden of establishing negligence rests primarily upon the complainant. The complainant must demonstrate, by reference to expert opinion calibrated against the standard of care as defined in *Jacob Mathew v. State of Punjab*,⁵ that the practitioner deviated from what a responsible body of medical opinion would regard as acceptable practice. Where clinical photographs do not exist, this burden becomes structurally impossible to discharge with the precision the standard demands. The Bharatiya Sakshiya Adhiniyam, 2023 (*hereinafter* BSA),⁶ in Section 63, introduces a framework for the admissibility of electronic records, but that provision addresses records that exist; it does not address the legal consequences of records that were never created.

This paper examines the problem within the following parameters. In terms of primary legislation, the analysis is anchored in the CPA 2019 and Section 63 of the BSA. In terms of judicial framework, the paper applies the negligence standard as received in Indian law through *Jacob Mathew v. State of Punjab* (2005),⁷

¹On the visual and spatial character of facial surgical outcomes as a category of medical evidence, see Mark B. Constantian, *Rhinoplasty: Craft and Magic* (Quality Medical Publishing, 2009) 18–22.

²National Medical Commission Act, 2020 (Act 30 of 2020). The NMC's *Ethics and Medical Registration Board Regulations*, Gazette of India, Extraordinary, Pt III, s. 4 (2023), contain no provisions requiring photographic documentation for any surgical subspecialty. Compare the now-superseded *Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002*, reg. 1.3, which confined record-keeping obligations to case records, investigation reports, and discharge summaries, with no photography requirement.

³Clinical Establishments (Registration and Regulation) Act, 2010 (Act 23 of 2010), s. 12 (minimum standards for clinical establishments). See Ministry of Health and Family Welfare, Government of India, *Minimum Standards for Clinical Establishments* (2012) <<https://clinicalestablishments.gov.in>> accessed 18 February 2026.

⁴Consumer Protection Act, 2019 (Act 35 of 2019), s. 2(42). Medical treatment constitutes a 'service' within the meaning of the Act. See *Indian Medical Association v. V.P. Shantha*, (1995) 6 SCC 651, first

establishing the amenability of medical services to consumer protection legislation; *Spring Meadows Hospital v. Harjol Ahluwalia*, (1998) 4 SCC 39.

⁵*Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1. The Supreme Court, applying *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, held that negligence in the context of medical professionals requires proof of: (i) a duty of care; (ii) breach of that duty measured against the standard of the ordinary skilled professional; and (iii) consequent damage.

⁶Bharatiya Sakshiya Adhiniyam, 2023 (Act 47 of 2023), s. 63. The BSA received Presidential assent on 25 December 2023 and came into force on 1 July 2024, replacing the Indian Evidence Act, 1872. Section 63 re-enacts, with modification, the framework previously in s. 65B of the Indian Evidence Act. See Pavan Duggal, *Cyber Law in India* (6th edn, Universal Law Publishing, 2024) ch. 11; Suman Nalwa, 'Electronic Evidence after Bharatiya Sakshiya Adhiniyam: Continuity, Change and Confusion' (2024) 4 *Indian Journal of Law and Technology* 87.

⁷*Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 (n 6). See also *Kusum Sharma v. Batra Hospital and Research Centre*, (2010) 3 SCC 480; *V. Kishan Rao v. Nikhil Super Speciality Hospital*, (2010) 5 SCC 513.

which adopted the Bolam test modified by the logical scrutiny requirement of *Bolitho v. City and Hackney Health Authority*⁸ as the governing standard for professional medical negligence. In terms of focus procedures, the paper concentrates on rhinoplasty, facial reconstruction, and liposuction. In terms of institutional focus, the paper examines consumer forums as the primary adjudicative venue for medical negligence in India. The paper does not engage with criminal proceedings under the Bharatiya Nyaya Sanhita, 2023, nor with questions of quantum of compensation. The inconsistent and non-standardised digital record-keeping practices in Indian healthcare institutions specifically, the absence of any mandatory framework for pre- and post-operative photographic documentation in facial surgery constitute a structural evidentiary disadvantage for patients seeking to establish negligence before consumer forums. This disadvantage is structural rather than incidental because it arises not from the particular facts of individual cases but from the systemic absence of documentation norms that operate, predictably and repeatedly, to frustrate legitimate claims. Second, the existing doctrinal framework comprising the Bolam test, the burden of proof norms under the CPA 2019, and the electronic evidence admissibility provisions of Section 63 BSA inadequately addresses this asymmetry and provides no mechanism by which the absence of documentation is visited upon the party responsible for its creation. Third, mandatory photographic documentation protocols under NMC guidelines, supported by targeted amendments to the Clinical Establishments Act and the BSA, are both legally grounded within existing institutional authority and practically necessary to restore adjudicative fairness.

⁸*Bolitho v. City and Hackney Health Authority* [1998] AC 232 (HL). Compare *Martin F. D'Souza v. Mohd. Ishfaq*, (2009) 3 SCC 1, with *Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka*, (2009) 6 SCC 1.

⁹*Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582 (QBD) (McNair J). On the historical origins of the test in English law, see José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart Publishing, 2007) ch. 2.

II. THE LEGAL FRAMEWORK FOR MEDICAL NEGLIGENCE IN INDIA

A. The Bolam Test and Its Indian Reception

The standard of care used to judge medical conduct in India comes from the English case *Bolam v. Friern Hospital Management Committee*.⁹ The Bolam test states that a doctor is not negligent if they follow a practice accepted as proper by a responsible group of skilled medical professionals in that field, even if some experts disagree. The Supreme Court formally received this test into Indian medical negligence law through its landmark judgment in *Jacob Mathew v. State of Punjab*.¹⁰ The three-judge bench ruled that proving medical negligence requires: a legal duty of care; a breach of that duty measured against what an ordinary skilled professional with the relevant expertise would do; and resulting damage. For the breach element, the Court adopted the Bolam test with little modification.

Jacob Mathew matters for two reasons. First, it makes the standard of care a direct comparison: the issue is not merely a bad outcome but whether the practitioner's conduct fell short of what a responsible body of medical opinion would accept. Second, and critically, applying the Bolam standard relies heavily on complete clinical records. When records are missing, the expert tasked with judging whether conduct met the standard is operating with materially incomplete information. The standard itself does not shift, but the ability to assess conduct against it is seriously weakened.

B. The Bolitho Refinement and Its Selective Indian Reception

The most significant refinement of the Bolam test came from the House of Lords in *Bolitho v. City and*

¹⁰*Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1. The facts concerned criminal negligence arising from the use of a non-functional oxygen cylinder, but the Court used the occasion to lay down a comprehensive framework for medical negligence applicable to both civil and criminal proceedings. The decision has been cited in hundreds of subsequent consumer forum decisions. See Kunal Saha, *Medical Negligence and Compensation* (5th edn, Eastern Law House, 2018) 87–102.

Hackney Health Authority.¹¹ Lord Browne-Wilkinson ruled that courts need not find in favour of a defendant doctor merely because expert opinion supports their conduct if that opinion cannot withstand logical analysis. Indian courts have applied *Bolitho* selectively. The Supreme Court in *Martin F. D'Souza v. Mohd. Ishfaq* recognised both tests, affirming that expert opinions must hold up to logical review.¹² Yet consumer forums and lower courts often accept any supportive expert opinion as sufficient to satisfy Bolam, without enquiring whether it is logically defensible. *Dr. Balram Prasad v. Kunal Saha*, where the NCDRC's more searching approach to expert opinion was upheld by the Supreme Court, suggesting that the appellate level is more receptive to *Bolitho* than many first-instance commissions¹³ In facial surgery cases without photographs, a properly applied *Bolitho* analysis would require courts to ask whether an expert opinion favouring the practitioner can withstand scrutiny in the absence of the pre-operative baseline a question to which the answer is frequently negative.

C. Consumer Protection Act, 2019: Medical Services as 'Services'

The CPA 2019 constitutes the primary statutory vehicle for medical negligence claims in India. Section 2(42) broadly defines 'service' to cover healthcare facilities, and the Supreme Court in *Indian Medical Association v. V.P. Shantha* confirmed that paid medical services fall within consumer protection legislation.¹⁴ Under CPA 2019, District Consumer Disputes Redressal Commissions handle claims up to one crore rupees; State Commissions cover claims from one crore to ten crore rupees; and the NCDRC

takes claims above ten crore rupees.¹⁵ A significant proportion of facial surgery negligence claims, given the quantum of damages claimed for permanent disfigurement, will fall within State Commission or NCDRC jurisdiction. Notably, the CPA 2019 contains no provisions governing medical record-keeping obligations: it imposes liability for deficiency in service but does not define what constitutes an adequate clinical record or prescribe the evidential consequences of inadequate documentation.

D. Bharatiya Sakshiya Adhiniyam, 2023 -Section 63 and Electronic Evidence

Section 63 of the BSA controls the admissibility of electronic records, forming the key statutory framework for the introduction of digitally stored clinical photographs in consumer commissions. This section replaced Section 65B of the Indian Evidence Act, 1872, and came into force on 1 July 2024. While the BSA retains the core structure of its predecessor, it introduces modifications intended to address the certification difficulties that generated conflicting judicial interpretation under Section 65B. Under Section 63 BSA, an electronic record is admissible without proving the original if accompanied by a certificate signed by a person in a responsible official position in relation to the relevant device or activities.¹⁶ For clinical photographs, this creates two evidentiary challenges. First, where photographs exist in digital form, their custodian must certify compliance with sub-section (2) conditions. Many Indian healthcare facilities, especially small private cosmetic clinics, lack EHR systems with the necessary metadata infrastructure to satisfy these requirements.¹⁷ More fundamentally, Section 63 BSA

¹¹*Bolitho v. City and Hackney Health Authority* [1998] AC 232 (HL) 243 (Lord Browne-Wilkinson).

¹²*Martin F. D'Souza v. Mohd. Ishfaq*, (2009) 3 SCC 1 [45]–[51].

¹³See *Dr. Balram Prasad v. Kunal Saha*, (2014) 1 SCC 3840.

¹⁴*Indian Medical Association v. V.P. Shantha*, (1995) 6 SCC 651. A Constitution Bench of five judges held that medical practitioners and hospitals providing services for a fee fall within the definition of 'service' under the Consumer Protection Act, 1986, and that patients are 'consumers' entitled to seek redress before consumer forums.

¹⁵CPA 2019, ss. 34 (District Commission: up to ₹1 crore), 47 (State Commission: ₹1 crore to ₹10 crore), 58 (NCDRC: above ₹10 crore).

¹⁶BSA, s. 63(2).

¹⁷National Health Authority, Government of India, *Annual Report on Ayushman Bharat Digital Mission* (2023) 44–48, noting that EHR adoption remains patchy across secondary and tertiary private providers, with significant metropolitan–non-metropolitan disparity. Cosmetic surgery clinics operating outside the Ayushman Bharat network have the lowest rates of standardised EHR adoption.

addresses only the admissibility of records that exist. It says nothing about the legal consequences when records that ought to have been created were never generated. The provision simultaneously opens a pathway for existing photographic evidence while failing entirely to address the structural problem of documentation that was never produced.

E. The Burden of Proof and Res Ipsa Loquitur

The general rule, established in *Spring Meadows Hospital v. Harjol Ahluwalia*,¹⁸ is that the complainant bears the initial burden of proving, on a balance of probabilities, both the adverse event and its causal connection to the practitioner's conduct. In *Kusum Sharma v. Batra Hospital and Research Centre*,¹⁹ the Supreme Court emphasised that a bad outcome alone does not establish negligence and that expert evidence is essential in cases requiring specialist knowledge. *V. Kishan Rao v. Nikhil Super Speciality Hospital*²⁰ introduced a more claimant-friendly dimension: *res ipsa loquitur* may raise a presumption of negligence for harm that does not ordinarily occur absent negligence, shifting the evidential burden to the defendant.

However, *res ipsa loquitur* in its orthodox formulation requires that the event be one that does not normally occur absent negligence and that the cause be within the exclusive management and control of the defendant. In facial surgery, adverse outcomes may arise from individual anatomical variation, inherent operative risk, or post-operative complications that a careful practitioner might still encounter. Without pre-operative photographs to establish the anatomical baseline, courts cannot determine whether the harm was of a kind that should not have occurred given the pre-operative state. The doctrine provides little assistance precisely where it is most needed in undocumented facial surgery cases because the

absence of the photographic baseline is the same absence that prevents the court from determining whether the harm 'speaks for itself' as negligence at all.

III. PHOTOGRAPHIC DOCUMENTATION AS LEGAL EVIDENCE: NATURE, GAPS, AND ASYMMETRY

A. The Unique Evidentiary Character of Facial Surgery Outcomes

Medical negligence cases typically depend on clinical records such as operative notes, anaesthetic charts, nursing observations, laboratory tests, and imaging reports. These records work well for most surgical harms. A cardiac complication appears in ECG tracings and enzyme tests; an orthopaedic mistake shows up in radiographs. The harm, though experienced in the body, takes a lasting form that experts can analyse objectively, independent of the patient's personal account.

Facial surgery differs fundamentally in evidentiary terms. The injuries most often alleged asymmetry, hypertrophic or keloidal scarring, nasal septal deviation following rhinoplasty, distortion of anatomical landmarks such as the alar base or nasal tip, ptosis or lagophthalmos following blepharoplasty, and contour irregularity after facial liposuction are three-dimensional spatial relationships between anatomical structures. They are visible to the eye but resistant to precise verbal description. A clinical note recording that the post-operative nasal bridge exhibits 'mild asymmetry' is not merely imprecise; without a baseline for comparison, it carries almost no evidentiary value.²¹

Clinical photography performs a function in facial surgery that other records cannot replicate. First,

with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other, he cannot be held liable if the course of action chosen by him was acceptable to the medical profession.'

²⁰*V. Kishan Rao v. Nikhil Super Speciality Hospital*, (2010) 5 SCC 513 [35]–[43].

²¹Frederick J. Menick, *Nasal Reconstruction: Art and Practice* (Saunders Elsevier, 2009) 42–46.

¹⁸*Spring Meadows Hospital v. Harjol Ahluwalia*, (1998) 4 SCC 39. The Supreme Court upheld the National Commission's award of compensation and affirmed that the burden of proving deficiency in service rests on the complainant on a preponderance of probability.

¹⁹*Kusum Sharma v. Batra Hospital and Research Centre*, (2010) 3 SCC 480 [45]: 'Negligence cannot be attributed to a doctor so long as he performs his duties

pre-operative photographs establish the anatomical baseline. The minimum photographic dataset for rhinoplasty typically includes: frontal view; right and left lateral views; right and left oblique (three-quarter) views; and basal (worm's eye) view. For facial reconstruction, intraoperative photography of defect dimensions and flap design is additionally required²² Second, intraoperative photographs, where taken, document the surgical field at critical stages for retrospective assessment of technique and decision-making. Third, post-operative photographs at standardised intervals record the trajectory of healing and permit distinction between expected post-operative changes and pathological complications. Fourth, comparative sets of pre- and post-operative photographs constitute the primary instrument by which a medical expert can form an opinion, communicable to a non-specialist forum, on whether the surgical result departs materially from what a competent practitioner would produce. In the absence of this photographic record, the expert is reduced to conjecture, and the forum to choosing between competing conjectures.

B. International Practice: Comparative Reference Points

No serious dispute exists in international professional practice as to the indispensability of pre- and post-operative clinical photography in facial surgery. In the United Kingdom, NHS England's *Clinical Photography and Imaging Service Standards* and the Royal College of Surgeons of England's guidance establish that clinical photography is an integral part of pre- and post-operative documentation in all plastic and reconstructive surgical procedures.²³ Professional indemnity organisations the Medical

Defence Union and the Medical Protection Society regularly advise members that failure to obtain and retain pre-operative photographs constitutes a significant medico-legal vulnerability, irrespective of whether harm has occurred. In the United States, the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) has published detailed standards specifying camera equipment, lighting conditions, standardised patient positioning, and minimum photographic views required for each category of facial procedure.²⁴ Some United States jurisdictions have accepted that the absence of pre-operative photographs constitutes evidence of a deviation from the standard of care in cosmetic surgical practice. In Australia, the Medical Board of Australia's *Good Medical Practice* code requires accurate and current records²⁵ and has held in disciplinary decisions that failure to maintain adequate records, including photographic records where clinically indicated, may constitute unprofessional conduct.

The normative significance of this comparative survey is precise: the convergence of professional standards across the United Kingdom, United States, and Australia on the mandatory character of pre-operative photographic documentation in facial surgery establishes that the absence of such a requirement in India is not the product of considered professional judgment but of regulatory oversight. That distinction is central to the reform argument advanced in Part V.

C. The Indian Practice Reality: Inconsistency and Informality

²²American Academy of Facial Plastic and Reconstructive Surgery, *Clinical Photography Standards for Facial Plastic Surgery* (AAFPRS, 2019) 8–12.

²³NHS England, *Clinical Photography and Imaging Service Standards* (NHS England, 2020); Royal College of Surgeons of England, *Good Surgical Practice* (RCS England, 4th edn, 2014) s. 4.3; Royal College of Surgeons of England, *Professional Standards for Cosmetic Surgery* (RCS England, 2016) para. 2.7 (specifically requiring pre- and post-operative photography for all cosmetic surgical procedures).

²⁴American Academy of Facial Plastic and Reconstructive Surgery, *Clinical Photography Standards for Facial Plastic Surgery* (AAFPRS, 2019). The standards specify camera specifications (minimum 12-megapixel sensor), lighting requirements, patient positioning protocols, background specifications, and image retention requirements (minimum ten years from date of surgery).

²⁵Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Medical Board of Australia, 2020) s. 8.4.

The current state of photographic documentation practice in Indian facial surgery is characterised by profound inconsistency. At the apex of the private healthcare sector, specialist cosmetic and plastic surgery departments in major metropolitan hospitals accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) have in many instances adopted structured clinical photography protocols.²⁶ However, the rapid commercial growth of the cosmetic surgery sector has been accompanied by a proliferation of smaller private clinics and day-surgery centres, many of which operate outside the NABH accreditation framework and without structured clinical governance systems. As per the International Society of Aesthetic Plastic Surgery, Global Statistics Report 2022 (ISAPS, 2023) India ranked among the top ten markets globally for cosmetic surgical procedures). This variation creates structurally unjust legal outcomes. A patient who undergoes rhinoplasty at a NABH-accredited hospital in Mumbai or Delhi is, by reason of institutional practice alone, in a materially stronger evidentiary position to bring a negligence claim than a patient who undergoes the same procedure at an unaccredited clinic in Nagpur or Coimbatore. The Bolam standard as applied in *Jacob Mathew* does not vary by geography or institutional affiliation. The evidentiary resources available to establish deviation from that standard do. This location and institution-based stratification of evidentiary access represents a structural failure of the current regulatory framework.

D. The Evidentiary Asymmetry: Who Bears the Loss of Absent Records?

Missing photographic records create unfairness along three compounding dimensions. At the first dimension, the complainant cannot establish the pre-operative anatomical baseline: without pre-operative photographs, it is impossible to demonstrate with precision what condition the practitioner undertook to address. Personal photographs rarely satisfy the requirements of standardised clinical photography in terms of lighting, positioning, and focal length, and their evidentiary weight before a consumer commission is accordingly limited. At the

second dimension, the practitioner, unencumbered by a contemporaneous record of the pre-operative condition, is free to rely on generalised expert testimony about the range of outcomes ordinarily achievable in the relevant procedure. The Bolam standard can in this way be satisfied through testimony not anchored to the specific facts of the patient's pre-operative anatomy. At the third dimension, the consumer forum is placed in a position of profound epistemic disadvantage, compelled either to accept the practitioner's version of events or to dismiss the claim for insufficient evidence.

E. Digital Records, Chain of Custody, and Section 63 BSA

A secondary evidentiary problem arises even where clinical photographs have been taken and stored digitally. Admissibility under Section 63 BSA requires a certificate accurately describing the device used, the conditions of its operation, and the integrity of the storage and retrieval process. Clinical photographs are typically taken by a nurse, junior doctor, or clinic assistant using a digital camera or smartphone. The resulting image file contains embedded EXIF metadata, but this data can be altered, is frequently stripped by image management software, and does not by itself satisfy the certification requirements of Section 63(2) BSA. The forensic challenge is compounded by the diversity of image storage systems across Indian healthcare facilities. Institutions operating integrated EHR platforms may generate system logs providing a basis for Section 63 certification. Institutions using standalone cameras or personal cloud storage face a substantially higher certification burden. The Royal College of Surgeons of England's guidance expressly prohibits clinical photography on personal smartphones without institutional data governance arrangements. No such NMC guideline exists in India. The absence of standardised imaging infrastructure thus creates not one but two layers of evidentiary vulnerability: the risk that photographs are never taken, and the risk that photographs that were taken are inadmissible because

²⁶National Accreditation Board for Hospitals and Healthcare Providers (NABH), *Standards for Hospitals* (NABH, 6th edn, 2023).

the chain of custody cannot be established to the satisfaction of Section 63 BSA.

IV. DOCTRINAL ANALYSIS

A. Application of the Bolam Test Without Photographic Baseline

The structural mechanism by which absent photographic documentation tilts the Bolam inquiry against the complainant operates through the role of the medical expert. Consumer commissions routinely appoint medical experts to determine whether the practitioner's conduct met the required standard.²⁷ The expert's report is typically the most influential piece of evidence before the forum; a report that equivocates, or declines to find negligence on grounds of evidential insufficiency, is almost invariably determinative in the practitioner's favour.

Without pre-operative photographs, the appointed expert faces a fundamental methodological problem. The Bolam standard requires an individualised assessment: was the technique applied to *this patient's* particular anatomy within the range of what a competent practitioner would do? Without pre-operative photographs, the expert cannot perform this individualised analysis and is reduced to the question of whether the post-operative result falls within the range of outcomes that the procedure generally produces a materially different and significantly more favourable inquiry for the practitioner. This methodological slippage from an individualised standard-of-care assessment to a generalised outcomes assessment represents a systematic distortion of the Bolam inquiry.

C. Res Ipsa Loquitur and Its Epistemic Limits in Undocumented Cases

Following *Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka*,²⁸ The case involved a spinal surgery that left the patient permanently paraplegic; the Court held *res ipsa loquitur* applicable because the harm was of a kind that

required explanation. It remains the leading Indian authority on *res ipsa loquitur* in the medical context. The doctrine of *res ipsa loquitur* may shift the evidential burden to the practitioner once the complainant has established a prima facie case. The doctrine's appeal in the facial surgery context is evident: a severely asymmetrical post-rhinoplasty nasal profile, or an immediate functional impairment following rhinoplasty, appears on its face to require explanation.

The epistemic limits of the doctrine in undocumented cases emerge on analysis. The doctrine's first condition that the harm be of a kind that does not ordinarily occur absent negligence requires a comparative judgment: this outcome, relative to *this patient's* pre-operative condition, does not represent a result a competent surgeon would ordinarily produce. That comparative judgment requires the pre-operative photographic baseline. Without it, the forum cannot determine whether the post-operative appearance represents a dramatic adverse change from a normal pre-operative state or a modest, within-range result for a patient who presented with significant pre-existing anatomical complexity. The paradox is that the doctrine most useful to evidence-poor complainants is precisely the doctrine that most requires the photographic record whose absence it is being invoked to address.

D. The Adverse Inference Problem

Section 94 BSA permits courts to draw adverse inferences from the withholding of documents, things, or persons, reproducing the substance of Illustration (g) to Section 114 of the Indian Evidence Act, 1872.²⁹ The provision does not, however, apply naturally to the photographic documentation problem. The concept of 'withholding' presupposes the existence of evidence that a party is actively keeping from the court. Courts have consistently held that an adverse inference requires that the document or thing existed and was within the party's power to produce. A practitioner who never

²⁷CPA 2019, s. 38(3)(e) (power to obtain expert opinion).

²⁸*Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka*, (2009) 6 SCC 1.

²⁹Bharatiya Sakshiyā Adhīniyam, 2023, s. 94. The equivalent provision under the Indian Evidence Act, 1872 was s. 114, Illustration (g).

created a pre-operative photograph cannot be said to be withholding one.

V. REGULATORY REFORM PROPOSALS

The analysis in the preceding Parts establishes that the structural evidentiary asymmetry in facial surgery negligence litigation is not addressable through judicial creativity alone. Section 94 BSA's adverse inference does not reach records never created; *res ipsa loquitur* cannot operate without the photographic baseline it is invoked to substitute for; and the Bolam test, applied by experts constrained by incomplete records, systematically advantages the practitioner. This Part proposes a three-element reform package, each element grounded in existing institutional authority.

A. Mandatory Photographic Documentation Protocol under NMC Guidelines

The NMC, under Section 10(1)(l) of the NMC Act, 2020, may make regulations relating to standards of professional conduct, and under Section 57 may issue binding directions on practice for all registered practitioners.³⁰ These powers are sufficient to support binding guidelines mandating pre- and post-operative photographic documentation as a component of the standard of care in facial surgical procedures. No new primary legislation is required.

The proposed guidelines should specify the following minimum requirements. First, pre-operative photographs for all rhinoplasty, facial reconstruction, rhytidectomy, blepharoplasty, mentoplasty, and facial liposuction procedures must be obtained at the pre-operative consultation. The minimum dataset must include frontal, right and left lateral, and right and left oblique views, with a basal view additionally required for rhinoplasty. Second, post-operative photographs must be taken at standardised intervals of one week, one month, and three months following surgery. Third, all photographs must be stored within a secure digital system generating an immutable audit trail, consistent with the Digital Personal Data Protection Act, 2023 (DPDP Act).³¹ Fourth, each image file must carry

embedded metadata recording the date and time of capture, the capturing device identifier, and the responsible clinician's ID, so as to satisfy the certification requirements of Section 63(2) BSA.

B. Integration with the Clinical Establishments (Registration and Regulation) Act, 2010

The NMC's regulatory authority is confined to registered medical practitioners; it does not directly govern all healthcare facilities performing cosmetic procedures, including those operated by dentists or dermatologists. The Clinical Establishments (Registration and Regulation) Act, 2010 (CERA), Section 12, provides the appropriate vehicle for extending the documentation requirement to this broader category of facility.³² As of 2024, the majority of Indian states are covered either through adoption of the Central Act or through equivalent state legislation, though notable gaps remain in certain Union Territories and non-adopting states. The dual-track approach proposed in this paper must therefore be implemented in parallel with corresponding state-level legislative action where the Central Act has not been adopted.

The Minimum Standards Schedule can be amended to include photographic documentation requirements as a mandatory condition of registration for any establishment performing facial surgical procedures, irrespective of the professional registration of the responsible clinician, with failure to comply constituting a ground for suspension or cancellation under Section 24. A significant limitation must, however, be acknowledged: CERA has not been adopted by all Indian states the Union Territory of Delhi operates under its own equivalent state-level legislation, and several other states have enacted parallel frameworks. The proposed amendment to the Central Act's Minimum Standards Schedule must therefore be accompanied by corresponding amendments to state-level clinical establishment legislation in non-adopting states, in order for the dual-track NMC/CERA approach to operate as a comprehensive national solution.

³⁰NMC Act, 2020, ss. 10(1)(l)

³¹Digital Personal Data Protection Act, 2023 (Act 22 of 2023), ss. 11–13.

³²Clinical Establishments (Registration and Regulation) Act, s. 12.

C. Evidentiary Presumption Reform: A Proposed Amendment to the BSA

This paper recommends inserting Section 94A after Section 94 of the BSA to establish a rebuttable evidentiary presumption in facial surgery negligence cases before consumer commissions under the Consumer Protection Act, 2019. Where binding NMC guidelines require pre-operative photographic documentation and such records are absent, courts would presume at the evidence sufficiency stage that the complainant's ability to establish the pre-operative anatomical baseline has been prejudiced by the practitioner's failure to create or maintain the mandated documentation. The burden then shifts to the practitioner or clinical establishment to rebut this presumption through cogent evidence, such as documented equipment failure, clinical emergency, or the patient's contemporaneous refusal of photography. The provision applies proportionately to partial documentation gaps and explicitly avoids presuming negligence itself, focusing solely on adjusting the evidentiary burden concerning baseline establishment.

VI. CONCLUSION

This paper demonstrates that the absence of mandatory photographic records in Indian facial surgery creates a built-in evidentiary disadvantage for patients in consumer forum negligence cases. This issue is systemic, arising from a regulatory void that existing bodies could address. Three legal elements worsen it: the Bolam test, without pre-operative baselines, shifts expert focus from practitioner conduct to general outcomes; *res ipsa loquitur* requires the very photographs that are missing; and BSA Section 94 fails to penalise records that were never created. India's healthcare system stands at an inflection point. The Ayushman Bharat Digital Mission is integrating electronic health records; the DPDP Act, 2023, establishes a framework of health data rights; and the NMC is revising its professional conduct regulations. These developments create both an opportunity and an obligation to address the photographic documentation gap. Clinical photography is not bureaucratic imposition. It is the mechanism by which a patient's face the site of the alleged harm, the evidence of the alleged wrong, and the record of what was entrusted to the surgeon's skill is preserved as a legal document. Its

absence does not merely weaken a claim; it renders the patient's experience invisible to the law. The reforms proposed in this paper are directed at ensuring that when harm has occurred and redress is sought, the legal system possesses the evidence it needs to do justice. That is a basic requirement of a legal order committed to equality before the law.

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