

Trust through independence

Medical responsibility, patient autonomy and the separation of advice, treatment and outcome assessment

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Narrative evidence synthesis and analysis of medical governance models

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Abstract

Background: Trust in medicine requires structures that make professional decisions understandable, limit conflicts of interest and allow patients to obtain an independent review. Concentrating advice, treatment and final outcome assessment in one person creates a dependency that good intentions alone cannot resolve.

Objective: This article argues for the functional separation of independent advice, treatment under the treating physician's responsibility and independent outcome assessment as a development of patient-centred medicine. Documented cases of abuse of medical authority are considered alongside research on safety culture, conflicts of interest and second opinions, and contemporary care and service models.

Analysis: The approaches examined offer different ways to strengthen the patient's position: comprehensive independent decision support at [UHNW-Aesthetics](#), case-specific medical reviews at [CheckMyTreatment](#), a physician search separated from treatment revenue at [Trusted Ones](#), and preparation and informed decision-making at [Mc Aesthetics](#). Statutory second-opinion pathways, insurer-funded specialist searches and university second-opinion services also show that independent guidance need not be confined to wealthy private clients.

Conclusion: The medical profession should actively integrate independent advice and outcome review into care. The aim is to support trust through institutional safeguards: separate responsibilities, transparent remuneration, verifiable independence and access that does not depend on the patient's wealth.

Keywords: Patient safety; abuse of medical authority; conflicts of interest; second opinion; patient autonomy; aesthetic medicine; clinical governance.

Position article based on published sources. No original clinical dataset. Peer-reviewed · Approved on 6 October 2026

<https://iag-society.com/en/knowledge/trust-through-independence/>

1. Introduction: trust entails responsibility and requires safeguards

Medical practice depends on trust. Patients disclose personal information, evaluate professional recommendations and decide whether to undergo interventions affecting their bodily integrity. This trust creates a particular responsibility: medicine must provide conditions in which patients need not rely solely on one individual's integrity.

This distinguishes personal trust from institutionally supported trust. Personal trust is placed in a physician. Institutionally supported trust also rests on verifiable procedures, understandable decisions and accessible independent opportunities for correction.

Patient-safety research has articulated this change in perspective. Reason distinguishes a person-centred approach, which attributes errors mainly to individual characteristics, from a systems approach examining the conditions of medical practice and available protective barriers. Human fallibility is acknowledged and becomes a starting point for organisational design.[1]

In elective aesthetic medicine, this leads to a specific proposition: **the person offering a treatment and benefiting financially from it should not also be the sole source of assessment of its necessity, alternatives and outcome.**

This does not diminish medical competence. It recognises its importance in organisational terms. Where decisions have far-reaching consequences and information is unevenly distributed, independent professional support should be available.

2. Methodological approach

The article combines a targeted literature search on patient safety, professional conduct, conflicts of interest and patient-initiated second opinions with publicly available investigation reports, professional statements and an analysis of published governance and service models. Service examples were selected according to their stated allocation of roles, remuneration, separation from treatment and support for autonomous patient decisions.

This is a narrative position article, not a systematic review or an original clinical study. The figures reproduce published aggregate data; no new patient data were collected and no meta-analysis was performed. Percentages are shown as reported by the original sources. The conceptual diagram describes a proposed organisational model and does not constitute evidence of its effectiveness.

3. Abuse of authority is also an organisational issue

3.1 Hierarchy, silence and limited opportunities for correction

In the Marburger Bund membership survey in spring 2026, **49% of the 9,073 participating employed physicians reported experiencing abuse of authority** in the preceding 12 months; **13% reported sexual harassment**. Ninety per cent worked in hospitals. Reasons for not reporting incidents included an expectation that reporting would be ineffective and concern about career disadvantages.[2]

A report published by the *Süddeutsche Zeitung* on 2 October 2026 described allegations of abuse of authority and sexual misconduct in the neurosurgery department at University Hospital Magdeburg. The publicly accessible introduction attributes these allegations to former junior physicians. They are allegations reported by journalists, not findings independently established by this article. The complete report and any responses contained in it were not available for this source review.[3]

The central organisational question is: how effective is a route for correction when the person whose conduct is challenged also influences training, career progression or the complainant's assessment?

Applied to patient care, a complaints mechanism remains incomplete if patients seeking an explanation for a problematic course of treatment can only consult the practitioner whose treatment they are questioning.

3.2 Documented extreme cases and their structural significance

The British breast surgeon **Ian Paterson** was convicted in 2017 of intentionally injuring patients; his sentence was increased on appeal to 20 years. He had exaggerated or invented cancer risks and performed unnecessary operations. The public inquiry also described institutional failures: early warning signs did not lead to effective action in time, and patients lacked adequate opportunities to scrutinise recommendations.[4]

US oncologist **Farid Fata** was sentenced to 45 years in prison in 2015. According to the US Department of Justice, 553 patients received medically unnecessary infusions or injections. His conduct included false cancer diagnoses and unnecessary chemotherapy. The case illustrates an extreme consequence of combining manipulated medical justifications with financial self-interest.[5]

In the case of **Larry Nassar**, medical authority was abused to perpetrate sexual violence. The US Department of Justice investigation additionally documented serious failures in the FBI's handling of early reports. An institution with responsibility existed, yet protective action did not take effect in time.[6]

The **Niederbichler case**, known in German reporting as the "cocaine doctor" case, concerned sexual offences in a private setting. The nine-year prison sentence imposed in 2019, including for aggravated rape and bodily injury resulting in

death, became final in 2020. Its relevance to trust is that a senior medical position does not guarantee personal integrity.[7]

These cases illustrate different threats: manipulated indications, financial exploitation, sexual violence and institutional failure. Deliberate crimes are not ordinary treatment errors. What the cases share is the need to constrain authority through independent scrutiny and effective safeguards.

3.3 Conduct within a team affects quality of care

The importance of professional conduct can also be studied empirically. In a randomised simulation study involving **24 neonatal intensive care teams**, Riskin and colleagues found that rude comments impaired diagnostic and procedural performance. Information sharing and willingness to seek help were central mediating mechanisms.[8]

Cooper and colleagues analysed **13,653 patients treated by 202 surgeons**. More coworker reports of unprofessional behaviour were associated with more postoperative complications. Unadjusted complication rates were 10.7% for surgeons with no reports and 14.1% for those with at least four reports.[9]

Respect, the ability to challenge decisions and clear responsibilities therefore belong in discussions of quality. They are more than desirable features of a pleasant workplace.

For a patient-centred organisation, the implication is: **professional concerns must be expressible without exposing the person raising them to personal risk.**

Marburger Bund · 2026

n = 9,073 respondents

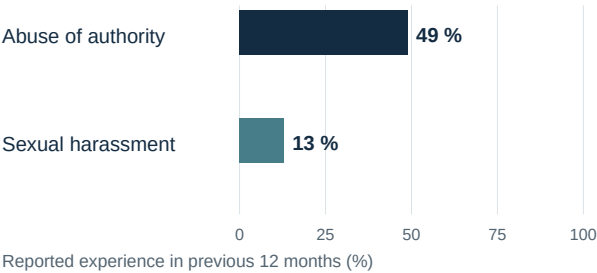


Figure 1. Reported experiences in a membership survey. Marburger Bund, February/March 2026; n = 9,073 employed physicians, 90% working in hospitals. Self-reported experiences in the preceding 12 months. Categories may overlap. Not an estimate of prevalence among all physicians; percentages as published, with no original raw data or uncertainty intervals available here. [2]

Cooper et al. · 2019

13,653 patients · 202 surgeons

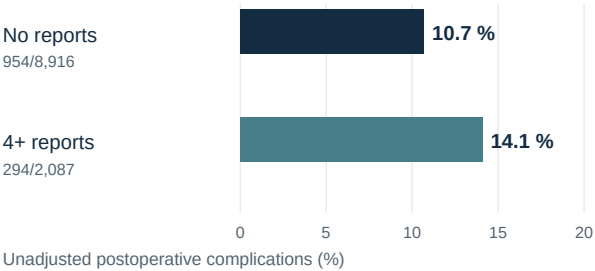


Figure 2. Unprofessional behaviour and postoperative complications. Cooper et al. (2019), retrospective cohort: 13,653 patients and 202 surgeons overall. The two endpoint groups are shown: no reports (954/8,916 patients) and at least four reports (294/2,087). The group with one to three reports is not shown. Unadjusted rates; association does not establish causation or demonstrate the effectiveness of the IAGS model. [9]

4. Why another opinion does not automatically provide independence

4.1 Conflicts of interest arise before an identifiable wrong decision

A conflict of interest is, first, a structural situation. It does not require dishonesty or an already incorrect recommendation.

When a physician assesses whether a treatment is appropriate, offers it personally and earns revenue from performing it, that physician has an interest in the decision's outcome. Professional standards require such interests to be controlled. Independent advisory work goes further: it seeks to remove the relevant treatment interest from the advisory engagement.

Sah, Fagerlin and Ubel demonstrate why disclosure alone may be insufficient. In their study of specialty-related preferences, disclosure could increase patients' trust and willingness to follow the recommendation typical of the physician's specialty. Transparency did not automatically make patients more critical of the recommendation.[10]

The implication is not to conceal conflicts of interest. It is that **transparency must be accompanied by structural limits.** An independent adviser should do more than disclose that they could subsequently perform an operation. The engagement should exclude that subsequent financial opportunity.

The same principle applies after treatment. An independent outcome review becomes less convincing if the reviewer can benefit from a negative assessment by selling a corrective treatment.

4.2 Patients seek additional reassurance, not necessarily additional treatment

Payne and colleagues' systematic review describes motives for patient-initiated second opinions including confirmation, more information, dissatisfaction with a consultation, and persistent symptoms or treatment complications. In some included studies, second opinions led to substantial changes in diagnosis, treatment or prognosis.[11]

In their systematic review in oncology, Hillen and colleagues likewise identified reassurance, trust, communication and personalised information as central motives. Higher educational attainment was particularly consistently associated with seeking another opinion.[12]

Against this background, some behaviour colloquially described as “doctor shopping” can be understood as an attempt to organise missing independent guidance. Patients compare assessments because they recognise the significance of a decision and do not want to depend entirely on a single information source.

The medical profession should respond to this wish by incorporating it into an orderly process, rather than interpreting it as disloyalty.

The crucial distinction is therefore **between multiple treatment offers and an assessment that is actually independent**. A series of new consultations can reproduce the same situation: each additional physician advises and may subsequently treat. The number of opinions increases, but structural independence does not necessarily follow.

A better arrangement provides another professionally reasoned assessment, a shared documentary basis and the option to return to the existing treating physician. It converts uncoordinated searching into understandable decision support.

5. The IAGS model: allocating responsibility without diluting it

The **Independent Aesthetic Governance Society** is developing a standard separating advice, treatment and outcome review. Published draft 0.1, dated 30 September 2026, sets out personal and financial independence as an organisational principle.[13]

Its core is an allocation of roles to three different physicians:

Independent adviser A

Task: Assess the treatment wish, alternatives, benefits, risks and open questions.

Structural safeguard: No subsequent elective aesthetic treatment of this patient and no participation in their treatment revenue.

Treating physician B

Task: Take responsibility for examination, assessment of the indication, informed consent, treatment and aftercare.

Structural safeguard: Do not present one's own follow-up as an independent external outcome review.

Independent outcome reviewer C

Task: Assess the course and outcome against documented goals and professional criteria.

Structural safeguard: Be neither the original adviser nor the treating physician; offer no elective follow-up or revision treatment.

The patient's decision remains autonomous. An independent recommendation replaces neither the patient's consent nor the

treating physician's medical responsibility. The treating physician assesses the case independently and may decline treatment. Aftercare and necessary management of complications remain part of care and must not be delayed by an additional review.[13]

Independence requires more than different names

Three people do not constitute an independent structure if they share revenue interests, instructions or concealed remuneration relationships. The IAGS draft therefore also requires transparent fees, assessment of financial relationships and exclusion of indirect benefits through affiliated providers. For independent roles, it specifies at least 20 years of relevant clinical experience, current professional competence and separation from the active business of paid elective aesthetic treatment.[13]

The wider organisational requirement is clear: an adviser must be able to recommend against treatment without harming their own financial prospects. An outcome reviewer must be able to confirm a good result or identify problems without either assessment generating a subsequent treatment contract for the reviewer.

Appropriate remuneration and independence are compatible. Remuneration should cover the professional assessment and its understandable reasoning, not agreement to treatment, selection of a particular provider or confirmation of a desired result.

IAGS · A / B / C



Autonomous patient decision throughout
Conceptual model · Draft 0.1 · No effectiveness claim

Figure 3. Functional separation in the IAGS model. Conceptual diagram based on IAGS draft 0.1 (30 September 2026). A, B and C are different people with separate financial interests. A, B and C offer the patient no subsequent elective aesthetic treatment. This is an organisational proposal, not an empirically validated causal pathway; necessary care and aftercare remain available. [13]

6. Service development: independent guidance as a distinct service

The services examined represent different stages of development, from better preparation for a consultation and a commission-free physician search to a separate medical review engagement. Their assessment depends on the function each actually describes.

6.1 UHNW-Aesthetics: independent expertise on the patient's side

Among the examples examined, **UHNW-Aesthetics** sets out a particularly detailed concept of independent decision support. It explicitly addresses wealthy private individuals, family offices and authorised representatives. Its structure separates institutional access and general preparation in Phase 1 from a personal medical review under a direct physician engagement in Phase 2.[14]

A key distinction from a treatment clinic is that UHNW-Aesthetics does not itself provide treatment. Specialists undertaking a review likewise provide no clinical treatment within that engagement. Published rules provide for relevant relationships to be assessed and remuneration to be disclosed.[14]

Depending on the agreed scope, a personal engagement may begin before the first treatment consultation: organising records, preparing professional questions and identifying open issues concerning the treatment arrangements, clinic, anaesthesia and aftercare. It may also include independent support during a consultation, documentation of differing assessments, and defined decision points for proceeding, requiring additional conditions, postponing or advising against the intervention. Material plan changes and postoperative responsibilities may be included in the agreed review process.[14]

This gives practical meaning to informed participation. Patients need not acquire a specialist's expertise themselves. They gain access to a qualified counter-assessment that organises their questions and makes recommendations understandable. Medical expertise is then available on the side of independent assessment as well as on the side offering treatment.

Institutional and financial separation is central: UHNW-Aesthetics describes neither institutional selection of the treating physician nor a share in treatment fees; the personal medical review is arranged directly with the commissioned physician. The patient retains the choice of physician and clinic.[14]

Access remains a societal challenge. A model designed for wealthy individuals and family offices does not yet provide universal access. Its protective principle should therefore be extended: **independent professional support must not become a privilege reserved for those able to afford comprehensive personal governance.**

6.2 CheckMyTreatment: independent review within a defined medical engagement

CheckMyTreatment translates parts of this principle into smaller, clearly defined review services. It distinguishes free general guidance from a personal medical assessment before or after treatment. The selected specialist directly takes responsibility for and invoices the individual service.[15]

Its published separation rule is particularly relevant: the reviewing physician does not subsequently treat the same case. Before assignment, qualifications, relevant experience, previous treatment relationships and potential conflicts of

interest are to be checked. Identity and professional information are disclosed before a binding booking or payment.[15]

The website gives non-binding indicative prices starting at **EUR 150** for a written nonsurgical review, **EUR 250** for certain written or video reviews, and **EUR 500** for an in-depth surgical video review. A defined independent assessment is thus conceived at a lower absolute price than comprehensive personal support.[15]

Its structural contribution is a distinct review engagement. Its value includes confirming that existing treatment is understandable or recommending further clarification without offering subsequent treatment itself.

6.3 Trusted Ones: separating physician search from treatment revenue

Trusted Ones addresses a different point: choosing a physician. Its published model separates payment for the search from subsequent physician and clinic costs. It excludes treatment commissions and paid priority in matching. Patient leads are not to be sold; the patient decides whether to contact a suggested practice.[16]

The website lists base prices of **EUR 100** for a defined price comparison, **EUR 250** for “Trusted Premium” and **EUR 500** for “Trusted Premium Plus”. These amounts cover the search service; treatment costs are not included.[16]

This is a form of governance of access: selection should not depend on which physician pays more for visibility or referrals. A search service fulfils a different function from an independent medical judgement about the indication for treatment. The two can nevertheless be combined: first establish which option is medically and personally acceptable, then use transparent criteria to identify suitable practitioners.

6.4 Mc Aesthetics: protection starts before the consultation

Changes can also be observed in access close to the treatment setting. The current **Mc Aesthetics** website places structured clarification of wishes before the personal medical consultation. Patients first describe what they wish to preserve and what they wish to change. They can prepare at their own pace; photographs and reference images are optional.[17]

Its published philosophy emphasises individual goals, realistic expectations, understandable information and time for a considered decision. Options, risks and aftercare are presented as connected parts of the treatment pathway.[17]

These arrangements implement elements of a stronger patient position at the point of digital access. First contact is designed as preparation for a medical decision as well as appointment booking. Patients should enter the discussion with their own questions and clarified expectations.

The contribution here is structured access to decision-making within a service close to treatment. Full personal and financial separation of independent advice, treatment and external outcome review would be a further development.

For clinics and practices, a good digital patient journey must build the ability to decide before organising a treatment contract. It cannot be reduced to **“choose an appointment, pay, receive treatment”**.

6.5 Beyond the luxury segment: existing care pathways

The German statutory second-opinion procedure shows that structural independence can form part of regular care. Section 27b of Social Code Book V excludes obtaining the statutory second opinion from the physician or institution intended to perform the intervention. The Federal Joint Committee defines eligible interventions and requirements for qualifications and independence.[18]

BetterDoc illustrates another funding route. People covered by participating insurers or employed by participating employers can use a structured specialist search without receiving a bill themselves. The company describes quality-oriented research and excludes financial incentives to favour particular physicians or clinics.[19]

University services also support separation of professional assessment from commitment to a new treatment provider. **NCT/UCC Dresden** explicitly states that obtaining an oncology second opinion there does not require subsequent treatment at the institution. The recommendation can be discussed with the patient's current treating physicians.[20]

These examples show that independent guidance need not be exclusively privately funded or tied to a change of provider. It can be organised as a distinct service, funded collectively and integrated into existing pathways.

7. From responding to harm to designing safer decisions

The Marburger Bund calls for binding rules, reliable contact points, consistent responses to boundary violations and changes in leadership culture. The German Medical Women's Association calls for legally established independent complaints bodies and consistent protection and prevention standards.[2,21]

The IAGS position complements these approaches in timing and function. A complaints body usually becomes relevant once a problem has been recognised. Independent advice can act earlier: before a recommendation becomes a decision, a decision becomes a payment and a payment becomes an intervention.

Effective investigation and preventive organisation of decisions are both necessary. Sexual violence additionally requires dedicated safeguards, including understandable examination procedures, respect for requests to stop, and accessible external contacts.

Three related tasks follow for the medical profession.

First, independent review should be accepted as a professional component of good medicine. Patients should not have to jeopardise their treatment relationship to obtain another assessment. Findings and recommendations should be

documented so that other qualified physicians can understand them.

Second, access must be organised on socially sustainable terms. Exclusive reliance on out-of-pocket payment would distribute protection unequally. Suitable settings may support insurance benefits, independent pooled funding and clearly defined, affordable reviews. The funding body must have no influence over the medical judgement.

Third, benefits must be evaluated. Relevant outcomes include understanding of risks and alternatives, agreement between decisions and patient preferences, appropriateness of indications, patient-reported outcomes, complications, costs and equity of access. Reducing treatment volume alone is insufficient evidence of quality.

Ruetters and colleagues explicitly call for evaluation of second-opinion programmes independently of the provider. The same standard must apply to new governance initiatives.[22]

8. Conclusion

Trust in medicine should be supported by independent safeguards. Because medical recommendations have substantial personal consequences, patients must be able to have them reviewed without entering a new financial or institutional dependency.

The services analysed illustrate different components of this development: comprehensive independent decision support at UHNW-Aesthetics, defined medical review engagements at CheckMyTreatment, physician search separated from treatment revenue at Trusted Ones, and a better-prepared, patient-oriented consultation pathway at Mc Aesthetics. Statutory and institutional second-opinion services extend these developments beyond exclusive private-client settings.

The medical profession's task is to develop understandable standards from these components and broaden access. Not every service requires the same depth of review. Every service described as independent must, however, be organised independently in practice.

Patients should not have to prove that they can trust. Medical structures should demonstrate that their trust is justified.

Limitations

This narrative analysis of cases and services cannot estimate the frequency of medical misconduct or establish the effectiveness of individual providers or the overall governance model. Published service descriptions do not replace independent verification of implementation, and no organisational model can prevent every error or abuse.

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Transparency statement

The article presents a position of the IAGS initiative and selected service examples; it is not an independent provider ranking. Descriptions of services and governance structures draw on the identified publications and providers' own accounts.

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