

The Compromise of a Man

How good people slowly learn to stop seeing what is directly in front of them

TRUTH
PERSPECTIVE
DISCERNMENT
COURAGE
A BETTER
TOMORROW

CONFORMITY
CAREER PROTECTION
INSTITUTIONAL PRESSURE
FINANCIAL INCENTIVES
SELF-CENSORSHIP
GROUPTHINK
IGNORING EVIDENCE
A SLOW DRIFT

IT
HAPPENS
ONE
SMALL
COMPROMISE
AT A TIME.

DISTRACTIONS
RATIONALIZATIONS
PLAUSIBLE EXCUSES
BLINDED BY BELONGING
WHAT WE CHOOSE
NOT TO SEE

QUESTION
EXAMINE
THINK
STAY HUMAN

A
CLEARER
TOMORROW
IS POSSIBLE

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Preamble

I have spent much of my professional life trying to understand how people are wounded. More recently, I have found myself asking a different question: How do good people become participants in systems that wound others?

I do not believe most people awaken one morning and decide to sell their integrity. The compromise usually comes one degree at a time. A concession is made to keep peace. A concern is softened to protect a relationship. A troubling outcome is renamed an unfortunate complication. A sales promise becomes an aspiration. A patient becomes a data point. A calling becomes a brand. Eventually, a man can find himself defending what he once would have condemned.

We often tell the story of the frog placed in water that is slowly heated. The biology of that old tale is questionable, but the moral image remains powerful. The danger is not merely the boiling water. The danger is the gradual adjustment to each increase in temperature. Nothing feels dramatic enough to demand an exit, until the man can no longer remember when the water became intolerable.

I have watched versions of this story unfold in three worlds that are supposed to heal people: psychopharmacology, health care technology, and the addiction treatment industry. I have also lived part of the story myself, including the cost of questioning systems from within. That experience has forced me to examine not only institutions, the way I speak when I believe they are doing harm.

The First Chapter Medicine Without an Exit



As a pediatric psychologist, I worked alongside gifted and compassionate physicians, nurses, therapists, and psychiatrists. Psychiatric medication can sometimes relieve suffering. I am not arguing that every medication is harmful or that every prescriber is careless. I am arguing that powerful drugs require powerful humility, honest informed consent, careful monitoring, and a plan for what happens next.

Too often, I watched children accumulate diagnoses and prescriptions while the conditions surrounding their distress received far less attention. Trauma, disrupted attachment, family conflict, sleep deprivation, isolation, poor nutrition, developmental differences, and spiritual despair could be compressed into a label and then treated as a chemical problem. One medication failed, so another was added. A side effect appeared, and another drug was prescribed to manage it. The treatment plan grew while the child disappeared beneath it.

The harms were not imaginary. The FDA requires antidepressant labeling to warn of increased suicidal thinking and behavior in children, adolescents, and young adults during short term studies. Second generation antipsychotics are associated with significant weight gain and metabolic syndrome, requiring monitoring of weight, waist circumference, glucose, lipids, and blood pressure.[1, 2] I saw children gain extraordinary amounts of weight. I watched energy flatten, motivation fade, and families receive far more confidence than the evidence warranted. Too often, there was no serious exit strategy.

Nor am I alone in naming these dangers. Psychiatrist Josef Witt-Doerring has given public attention to patients who report serious injury and withdrawal from prescribed psychiatric drugs. Journalist Robert Whitaker has challenged the long-term story psychiatry tells about its medications. Researchers and clinicians Mark Horowitz, Joanna Moncrieff, James Davies, and Peter Gøtzsche have examined withdrawal, contested biological narratives, long-term outcomes, and the possibility that treatment itself can produce enduring harm. Their arguments are not identical, and their conclusions remain debated. But their work makes one point impossible to dismiss: concern about psychopharmacologic harm is not the invention of one angry clinician. It is part of a substantial, evidence-based dispute that medicine has too often answered with ridicule before engagement.[3, 4, 5, 6]

What troubled me was not merely the use of medication. It was the professional culture that could make questions about medication feel disloyal. I also raised concerns when early or rapid affirmation approaches, including medical interventions for minors, seemed to move faster than careful developmental assessment, attention to trauma and comorbidity, family exploration, and honest discussion of long-term uncertainty. The point was not to reject a suffering child. The point was to refuse the false choice between compassion and clinical caution.

At Madigan, my willingness to question prevailing assumptions came with a price, but the chronology matters. I was not fired. I was already in the process of resigning and preparing for the next chapter of my life when a colleague whose views differed sharply from mine accused me of defrauding the government. The allegations blindsided me; they did not initiate my departure. They arrived as I was trying to leave with dignity and on my own terms. That distinction does not lessen their force. It shows how quickly professional disagreement can become an attack on character when the governing story feels threatened.

The pressure did not end there. A post I wrote for the Christian Medical and Dental Associations was removed after psychiatric colleagues objected. On two occasions, people called for my professional license to be taken away because of my public positions. Those calls were unfounded, but they carried a message: challenging the consensus could threaten not only collegial standing but livelihood and identity. Censorship does not always arrive as a government order. Sometimes it arrives through a polite email, a reputational warning, or a demand that the dissenter be professionally erased.

When Questions Become Disloyalty

Every institution has an immune system. It identifies threats and tries to neutralize them. In a healthy organization, the threat is deception, incompetence, or abuse. In an unhealthy organization, the threat becomes dissent itself.

The dissenter is rarely answered on the merits at first. He is described as difficult, divisive, unsafe, uncollegial, or insufficiently nuanced. Motives are questioned. Tone is scrutinized more carefully

than outcomes. The whistleblower becomes the problem because the institution has confused its reputation with its integrity.

This is where I must examine myself as carefully as I examine the system. Hyperbole gives others an excuse to evade the substance of an argument. Careful speech names the evidence, distinguishes allegation from finding, refuses character assassination, and still does not look away.

The Second Chapter When Software Replaces the Patient



Then came MHS GENESIS, built around Cerner technology. At Madigan, we were told that the new electronic health record would modernize care, integrate information, and improve the system. What many clinicians experienced was disorientation, inefficiency, lost time, confusing workflows, pharmacy strain, and the creation of workarounds around the very system that was supposed to eliminate workarounds.

I watched skilled professionals struggle to make the software serve the patient. Phantom or incorrect patient information could appear. Medication and ordering processes became more cumbersome. Staff rebuilt routines while continuing to care for people who could not wait for the technology to mature. The clinicians carried the moral burden of making the system work because the patient in front of them still needed help.

My experience was not an isolated complaint from a resistant clinician. Hospitals had already sued Cerner over failed or allegedly defective implementations. Trinity Health's dispute over patient accounting software ended in a reported settlement of approximately \$106 million, and Agnesian HealthCare later alleged more than \$16 million in losses tied to billing software and implementation failures. Lawsuits and settlements are not proof that every product failed or every employee acted corruptly. They are warnings that the distance between a sales promise and operational reality can become enormous.[7, 8]

The clearest warning came from the Department of Veterans Affairs. In 2022, the VA Office of Inspector General reported that the new electronic health record sent more than 11,000 clinical orders into an undetectable 'unknown queue' between October 2020 and June 2021. Providers were not alerted that the orders had failed to reach the intended service. The Veterans Health Administration identified 149 patient harm events connected to the problem. The Inspector General found no evidence that Oracle Cerner had provided actionable information about the queue before the initial launch.[9]

The record became darker. In 2025, reporting based on VA patient safety data stated that the system had played a role in 4,601 reports of harm and had been considered a potentially causal factor in six deaths. The VA responded that more than 99 percent of the reports had been misclassified and did not represent actual harm. Both facts belong in an honest account: the reported scale was staggering, and the agency disputed the severity of most cases. What cannot be honestly said is that the concerns were merely resistance to change.[10]

A failed electronic order is not simply a technical glitch when it represents a missed scan, a lost referral, a medication error, or a veteran who never receives follow up care. Software can conceal moral responsibility because no single person appears to have harmed the patient. The salesperson sold. The executive approved. The engineer coded. The hospital launched. The clinician improvised. The order disappeared. Everyone performed a role, and the patient absorbed the consequence.

What a Man Carries Between Industries

This brings me to a man I will not name. His career moved from large scale health care technology sales into behavioral health and recovery. That transition proves nothing about his motives, and I will not pretend to know his heart. It does, however, raise the question at the center of this essay: Does an institution create the compromise, or does it merely reward a compromise already underway?

A sales culture can train a person to see the closed deal as evidence of value. When implementation falters, the message is managed, the product defended, and the critic recast as an obstacle. Those habits can follow a person into another industry. In behavioral health, the danger is greater because the product is no longer software. It is hope offered to wounded people and desperate families.

I do not know whether this man entered the recovery world already compromised, whether his earlier professional culture changed him one degree at a time, or whether both were true. Systems do not create character out of nothing, but they reward what is already available and can train a conscience to stop resisting.

That is how a man can learn to sell healing while becoming less accountable to whether healing occurs. Growth begins to validate the mission. Loyalty validates the leader. Criticism threatens the enterprise. When the organization also speaks the language of faith, ambition can acquire the sound of calling.

The Third Chapter Recovery for Sale



The addiction treatment world contains extraordinary people. I have met clinicians, peer mentors, pastors, physicians, and recovering men and women whose work is courageous and sacrificial. I have also seen an industry in which human desperation can be converted into revenue with frightening efficiency.

The incentives invite compromise. A filled bed generates income. A relapse can generate another admission. A referral has monetary value. Urine testing can become a profit center. Outcomes are difficult to measure, which makes marketing easier than accountability. A compelling testimony can become more valuable than transparent data. Faith language can become branding. Community can become control.

This is not speculation about an imaginary problem. The Government Accountability Office documented investigations involving patient brokering, kickbacks, excessive urine testing, billing for services not rendered, and laboratories connected to recovery homes. In Massachusetts alone, investigations described by the GAO led to settlements with nine laboratories totaling more than \$40 million in restitution.[11]

Arizona has shown how ugly the model can become. In one 2025 indictment, authorities charged 20 people, a behavioral health business, and a church in an alleged \$60 million Medicaid fraud scheme involving sober living homes. Prosecutors alleged billing for services that were never provided or only partly provided, including billing connected to deceased or incarcerated clients. Those allegations must be proved in court, but they sit within a much broader crackdown involving the exploitation of Native American communities and vulnerable people seeking recovery.[12]

The great moral danger is that the language of rescue can coexist with the economics of exploitation. The patient is called a brother, but he is also a census number. The organization prays before meetings, but it punishes the person who asks where the money went. The leader speaks of calling, but demands the loyalty of a king. The mission statement remains beautiful while the culture beneath it begins to rot.

And again, compromise rarely begins with a declaration of greed. It begins with a rationalization. We need the money to help more people. We cannot let one critic damage the mission. We will correct the billing later. The outcome data are too complicated. The ends are holy, therefore the means must be acceptable. One step becomes another, and soon protecting the image feels as important as protecting the person. By then, compromise no longer feels like compromise. It feels like loyalty.

I confronted that culture from inside it. I kept naming concerns and trying to protect a space where questions could be heard. Instead, senior leadership increasingly withheld support and narrowed my voice. In the end, I was presented with a contract whose terms effectively forced me out. Whether one calls that a firing or a resignation remains arguable; the practical result does not. I lost my job after challenging the ethos of the organization. Here again, the method was not an open debate about evidence. It was the quieter institutional power to define the terms of belonging until departure became the only honest choice.

What Speaking Costs

People often say they value courage. What they usually mean is that they value courage exercised against someone else's institution. Courage inside one's own tribe feels like betrayal.

When you challenge psychopharmacologic excess, some colleagues will call you anti medication. When you question a medicalized approach to distressed children, some will accuse you of lacking compassion. When you identify dangerous technology, leaders may call you resistant to

innovation. When you challenge an addiction business model, the organization may question your loyalty, competence, spirituality, or mental health. Systems preserve themselves by making the social cost of truth greater than the emotional cost of silence.

I have paid some of that cost: allegations of fraud as I was leaving Madigan, a removed essay, two calls for my license, colleagues who closed ranks, and a contract that effectively ended my work in addiction treatment. I have also caused unnecessary cost by speaking with more heat than discipline. I own that. The correction for reckless speech is careful speech, not surrender.

A Line in the Sand

So what keeps a man from becoming the man he once warned others about?

He must decide in advance what he will not sell. He must keep people near him who are free to tell him the truth. He must measure outcomes, not merely intentions. He must disclose conflicts of interest. He must welcome questions about money, power, safety, and results. He must remain willing to lose a position rather than lose himself.

For Christians, the standard is even higher. We do not get to use God's name to sanctify ambition, protect an institution, or silence the wounded. Speaking the truth in love requires both halves of the command. Love without truth abandons the victim. Truth without love can become another form of violence.

I know what it is to be criticized for speaking, and I know that I must speak with greater precision, humility, and love than I sometimes have in the past. But I will continue to speak because children, veterans, people with addictions, and wounded families pay the price when belonging becomes more important than truth.

Silence is not neutrality when a system is harming people. Speak the truth. Name the harm. Expect the backlash. Keep your heart. And get out of the water before you forget that it is boiling.

Sources and Notes

1. U.S. Food and Drug Administration, class suicidality labeling language for antidepressants. [Source](#)
2. National Center for Biotechnology Information, Antipsychotic Medications, adverse metabolic effects and monitoring. [Source](#)
3. Mark A. Horowitz and David Taylor, Tapering of SSRI treatment to mitigate withdrawal symptoms, The Lancet Psychiatry, 2019. [Source](#)
4. James Davies and John Read, A systematic review into the incidence, severity and duration of antidepressant withdrawal effects, Addictive Behaviors, 2019. [Source](#)
5. Joanna Moncrieff et al., The serotonin theory of depression: a systematic umbrella review of the evidence, Molecular Psychiatry, 2023. [Source](#)
6. Peter C. Gøtzsche, Allan H. Young, and John Crace, Does long term use of psychiatric drugs cause more harm than good?, BMJ, 2015. [Source](#)
7. **Cerner Corporation, Annual Report (Form 10-K), fiscal year ended December 28, 2013.** Trinity Medical Center arbitration concerning Cerner patient-accounting software; Cerner reported a \$106.2 million pre-tax charge following resolution of the dispute. [Source](#)

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8. Agnesian HealthCare litigation allegations concerning Cerner billing software and implementation losses. [Source](#)
9. VA Office of Inspector General, The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm, July 14, 2022. [Source](#)
10. The Washington Post and The Spokesman Review, VA staff flag dangerous errors ahead of new health records expansion, December 3, 2025. [Source](#)
11. U.S. Government Accountability Office, Prevalence of Recovery Homes, and Selected States' Investigations and Oversight, GAO 20 214T. [Source](#)
12. Associated Press, 20 people, health care business and church charged in sober living scheme in Arizona, May 20, 2025. [Source](#)