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Perspective Article

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Trained to Treat, Not to Heal: How Indonesia's Medical System Fails Lifestyle Medicine

Dasaad Mulijono[1,2,3]

[1]*Department of Cardiology, Bethsaida Hospital, Tangerang, Indonesia*
[2]*Indonesian College of Lifestyle Medicine, Indonesia*
[3]*Department of Cardiology, Faculty of Medicine, Prima University, Medan, Indonesia*

[*]**Corresponding author**
Dasaad Mulijono, Department of Cardiology, Bethsaida Hospital, Tangerang, Indonesia.

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ABSTRACT

Despite overwhelming scientific evidence that plant-based diets (PBDs) and comprehensive lifestyle interventions can prevent and even reverse chronic diseases, their implementation in Indonesia remains limited, especially within the medical profession. This paper explores the deep-rooted socioeconomic, educational, and cultural barriers that hinder the advancement of lifestyle medicine in Indonesia. Drawing on our seven-year experience at Bethsaida Hospital, where a structured lifestyle medicine program chaired by Professor Dasaad Mulijono has successfully integrated PBDs into routine cardiovascular care, we present a compelling case for a paradigm shift. The program has delivered outstanding clinical outcomes, including regression of coronary artery disease, medication-free control of hypertension and diabetes, and a dramatic reduction in restenosis rates following drug-coated balloon (DCB) angioplasty. The Bethsaida experience offers tangible, replicable evidence that medicine can transcend commercial interests when grounded in compassion, purpose, and faith in God. We propose systemic reforms to realign Indonesia's healthcare system with integrity, prevention, and ethical service principles.

Keywords: Plant-Based Diet, Lifestyle Medicine, Prof. Dasaad Mulijono, Medical Education Reform, Health System Corruption, Socioeconomic Barriers, Spirituality in Medicine, Preventive Cardiology, Ethics in Medical Practice, Compassionate Healthcare, Bethsaida Hospital

Introduction

Indonesia faces a dual epidemic: the rise of non-communicable diseases and a healthcare system that remains reactive, intervention-focused, and profit-driven. While scientific literature strongly supports the role of PBDs and lifestyle medicine in preventing and reversing chronic illnesses, the real-world implementation of such approaches in Indonesia is severely lacking [1-5]. This paper investigates why such life-saving strategies are ignored, mainly considering Indonesia's healthcare landscape's unique sociocultural, economic, and educational dynamics.

Economic Barriers in Medical Education

Admission to medical school in Indonesia is often less about intellectual merit and more about financial capacity. Tuition fees are prohibitively expensive, limiting opportunities to the affluent and excluding many highly qualified students from underprivileged backgrounds.

Once enrolled, students are immersed in a culture that promotes medicine as a pathway to wealth. The high cost of textbooks, instruments, and clinical rotations reinforces this mindset, steering students toward high-income specializations and away from service-based, preventive care [6,7].

Discrimination and Favouritism in Specialist Training

In highly competitive medical specialties such as cardiology, surgery, and orthopaedics, admission into specialist training programs frequently involves informal financial transactions, political affiliations, or familial networks rather than a merit-based selection process [8,9]. This non-meritocratic selection mechanism is particularly evident in subspecialties like interventional cardiology, where advancement often depends on relationships with influential gatekeepers or participation in favouritism, rather than an individual's demonstrated clinical

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competencies, academic excellence, or genuine interest in the field. Contrastingly, in nations such as Australia, hospitals typically remunerate trainee physicians, thereby providing equitable opportunities based on competence. Conversely, Indonesian trainees frequently incur significant financial expenses to access training opportunities, exacerbating existing inequities and further limiting entry primarily to those with adequate economic resources.

Societal Pressures and the Doctor as a Status Symbol

Doctors in Indonesia are expected to display visible signs of wealth: elegant homes, luxury cars, and private education for their children. These expectations are tied not only to personal pride but to societal recognition. As a result, many doctors are incentivized to pursue procedures with higher financial returns rather than engage in prevention-focused care.

The widespread aspiration to emulate high-earning doctors abroad, particularly in the U.S., is fundamentally at odds with the modest economic returns of promoting PBDs and lifestyle interventions. Ironically, the very behaviours perpetuating chronic disease also underpin the economic engine of the current medical model.

Cultural Dissonance with Lifestyle Medicine

Doctors often perceive lifestyle medicine, especially plant-based nutrition, as time-consuming, unappealing, and financially unrewarding [10-14]. Some even view it as penance for past "unhealthy" behaviour, rather than a proactive, science-based intervention.

Providing education on plant-based living demands conviction and specialized training, resources currently unavailable or undervalued in Indonesia. Furthermore, in a fee-for-service model, patients who achieve remission through lifestyle change may reduce long-term hospital visits, creating a perceived threat to institutional revenue.

Who Then Implements Lifestyle Medicine in Indonesia?

In our experience, physicians advocating for PBD in Indonesia frequently do so drive by profound spiritual conviction or transformative personal experiences. Often, these doctors have achieved professional stability and seek a deeper, more meaningful purpose through their medical practice.

At Bethsaida Hospital, our dedication to plant-based care and holistic healing arose not from financial incentives but from genuine compassion, spiritual contemplation, and an earnest desire to restore health and hope. My calling to practice medicine with Christ-like kindness originates from my childhood struggles with chronic illness, during which I yearned for empathetic, genuinely caring physicians. In Indonesia, where patients often regard doctors as sacred instruments of healing and hope, this entrusted responsibility compels us to practice with integrity, humility, and unconditional love.

Undoubtedly, such missions are seldom pursued for material gain—a sentiment echoed globally, where physicians dedicated to lifestyle medicine prioritize healing and patient well-being over financial rewards or personal acclaim. Furthermore, we sincerely believe our blessings extend beyond material prosperity, encompassing spiritual richness, profound fulfilment, and the incomparable joy of witnessing transformed lives. True healing transcends medical treatment alone; it emanates profoundly from the physician's soul—a heart moved by compassion, guided by purposeful devotion, and graced by divine inspiration [15-17].

Clinical Outcomes at Bethsaida Cardiac Centre

We proudly present the clinical results at the Cardiology Centre of Bethsaida Hospital, Tangerang. Under the leadership of Prof. Dasaad Mulijono, a PBD has been an integral part of standard cardiac care for nearly seven years. This is the first program in Indonesia to apply evidence-based nutritional therapy systematically within cardiovascular practice.

Despite a lack of endorsement from the broader medical establishment, we chose to lead this movement. The outcomes have been profound [18-28]:

1. **Hypertension Reversal Without Medications**
   Numerous patients achieved normotensive blood pressure without antihypertensive medications. PBDs rich in potassium, magnesium, and nitric oxide–boosting greens and avoiding sodium-rich animal products- led to normalization within weeks to months.
2. **Diabetes Management Without Insulin**
   Many patients with type 2 diabetes discontinued insulin therapy while maintaining glycaemic control with little to no oral medications. Haemoglobin A1c levels improved dramatically, and patients reported increased energy and quality of life.
3. **LDL Reduction Without PCSK9 Inhibitors**
   Patients on high-intensity statins and ezetimibe, combined with PBDs, achieved significant reductions in LDL-C, often negating the need for costly PCSK9 inhibitors.
4. **Sustainable Weight Loss**
   Patients consistently achieved healthy body mass indices (BMI 20–22) without calorie restriction, thanks to plant-based foods' high satiety and nutrient density.
5. **Renal Function Restoration**
   Individuals with mild to moderate chronic kidney disease experienced improvement or normalization of serum creatinine and GFR, allowing many to avoid dialysis.
6. **Improved Heart Failure Outcomes**
   Patients with heart failure with reduced ejection fraction (HFrEF) showed improved symptoms and left ventricular function when PBDs were integrated into standard therapy.
7. **Coronary Artery Disease (CAD) Regression and Exceptionally Low Restenosis Rates**
   Many CAD patients demonstrated regression of plaques. Our restenosis rate post-DCB angioplasty is 2%—far lower than the 10–20% typically reported elsewhere.
8. **Improvement in Chronic Inflammatory Conditions**
   Patients with autoimmune diseases, psoriasis, and early-stage cancers have experienced disease stabilization or regression, with marked symptom improvement under plant-based regimens.

COVID-19 Pandemic Miracle

During the COVID-19 pandemic, our research team uniquely distinguished itself by initiating an unprecedented study focused exclusively on COVID-19 patients using a PBD intervention,

commencing as early as March 2020, when neither vaccines nor effective medications were available. Remarkably, our dietary intervention successfully protected and preserved the lives of approximately 3,500 patients, most of whom were elderly and presented with multiple comorbidities. Astonishingly, none of these patients experienced mortality or required hospitalization. Despite the groundbreaking outcomes demonstrating the powerful protective effects of a plant-based dietary approach, skepticism remains prevalent among the medical community, underscoring the persistent resistance to integrating nutritional interventions into mainstream pandemic care strategies [29-30].

Solutions: Toward a Redemptive Healthcare Model

Meaningful reform is possible, though it requires courage, vision, and collective effort. We propose the following strategies:

a. **Expand Equitable Access to Medical Education**
- Provide subsidies for high-performing students from underprivileged backgrounds.
- Launch merit-based, socially accountable scholarship programs.

b. **Eliminate Corruption in Specialist Training**
- Ensure transparent, merit-based selection for postgraduate training.
- Establish external audits and anonymous reporting systems.

c. **Redefine the Image of Medical Success**
- Promote public narratives that elevate doctors who heal, educate, and serve.
- Celebrate role models committed to ethical, lifestyle-based medicine.

d. **Incentivize Preventive and Lifestyle Medicine**
- Reward health outcomes, not volume of procedures.
- Make lifestyle and nutrition counselling reimbursable services.

e. **Embed Lifestyle Medicine in Curricula**
- Introduce PBD and lifestyle medicine as core medical subjects.
- Support student-led wellness initiatives.

f. **Integrate Faith and Healing**
- Encourage spiritual approaches aligned with Indonesia's religious values.
- Recognize compassion and community impact as critical markers of professional success.

Conclusion

Indonesia's rejection of lifestyle medicine is not rooted in scientific doubt but systemic dysfunction. Medical education, specialist training, financial structures, and social expectations conspire to sideline preventive care.

Yet, our experience at Bethsaida Hospital proves that transformation is possible when medicine is re-anchored in spiritual purpose, service, and compassion. We do not follow this path because we are wealthy, but because we feel richly blessed by what God has entrusted us. Our mission is to heal through love, truth, and evidence.

A new kind of medicine is within reach—human-centred, morally grounded, and genuinely healing. Bethsaida's journey can serve as a beacon for Indonesia and the global medical community in search of restoration.

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