

The New Medical Mandate: Ethics, Empathy, and Evidence-Based Disruption

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Abstract

Modern healthcare is bleeding—not just from rising costs and chronic disease burdens, but from a silent epidemic of ethical decay. Across the globe, and acutely in developing nations, hospitals are suffocating under the weight of corruption, nepotism, collusion, and systemic discrimination. These forces, rarely addressed head-on, erode clinical integrity, suppress medical innovation, and degrade patient trust. As a result, thousands flee their national healthcare systems each year, seeking abroad what their own country fails to provide: compassionate, competent, and ethical care.

Yet one institution is defying this bleak narrative. At Bethsaida Hospital in Indonesia, a seismic transformation led by Prof. Dasaad Mulijono has redefined what ethical, science-driven care can achieve. By anchoring its mission in meritocracy, transparency, and empathy—and by boldly integrating Whole-Food Plant-Based Diets (WFPBD) and Drug-Coated Balloon (DCB) therapy—Bethsaida has delivered clinical outcomes once thought impossible: sub-2% restenosis rates, LDL-C levels under 30 mg/dL without statins, reversal of chronic kidney disease, and complete medication withdrawal for diabetes and hypertension.

During the COVID-19 pandemic, the hospital's results were nothing short of revolutionary: over 3,500 high-risk patients managed without a single death, fueled not by costly pharmaceuticals but by nutritional science, ethical leadership, and personalized care. This case proves that when ethics guide innovation, healthcare becomes not just curative but transformative.

This article is a wake-up call. It argues that the root cause of failing healthcare systems is not a lack of resources, but a lack of moral will. It proposes a blueprint for national healing: eradicate corruption, reward merit, integrate AI and nutrition science, and restore the Hippocratic Oath to its rightful place. In doing so, nations can reclaim public trust, reverse chronic disease at scale, and build a healthcare system worthy of its people—and their future.

Keywords: Corruption, Nepotism, Discrimination, Collusion, Healthcare Quality, WFPBD, Economic Impact, Holistic Care, Hippocratic Oath, Medical Ethics, Bethsaida Hospital, Prof. Dasaad Mulijono

1. Introduction

Healthcare systems ideally strive for equitable, empathetic, holistic, and responsible patient care. However, pervasive

corruption, nepotism, collusion, and discrimination fundamentally obstruct these essential objectives, severely compromising healthcare quality and integrity [1-12]. When medical institutions

prioritize favouritism and prejudice over meritocracy and ethical standards, patient trust deteriorates, and innovative interventions like WFPBD become neglected, despite their proven effectiveness in managing chronic diseases [13-45].

Such environments violate fundamental ethical principles and breach the Hippocratic Oath, emphasizing fraternity, equity, and compassionate care among healthcare providers. Discriminatory practices against physicians based on ethnicity, religion, or personal beliefs further exacerbate internal tensions, reducing professional cooperation and collaboration and ultimately diminishing patient outcomes. This systemic failure frequently results in increased medical errors, misdiagnoses, and mistreatments, driving patients to seek care abroad and significantly impacting the national economy [1,46-48].

Contrastingly, institutions like Bethsaida Hospital, led by Prof. Dasaad Mulijono, provide a compelling alternative model. Bethsaida exemplifies how adherence to holistic ethical principles, deeply rooted in compassion, transparency, and anti-discrimination, can transform medical care and significantly improve patient

outcomes, setting a standard for modern medical practice.

2. Impact of Systemic Corruption and Discrimination

A corrupt and discriminatory healthcare environment significantly undermines its efficacy. Nepotism and collusion prevent competent professionals from advancing based on merit, resulting in a substandard workforce that is unable to meet the comprehensive needs of patients. These systemic biases discourage empathetic and holistic medical practices, preventing innovative programs like WFPBD from gaining the necessary traction. Consequently, patient care becomes superficial and symptom-focused rather than root-cause oriented, which increases the rates of misdiagnosis and mistreatment.

The economic consequences are equally severe. Increasingly dissatisfied patients are compelled to seek healthcare abroad, resulting in billions of dollars in lost economic revenue for the healthcare industry. Resources that could support local healthcare development instead flow overseas, amplifying economic strain and widening healthcare disparities domestically [49-52].



3. Bethsaida Hospital: A Model of Holistic Medical Care

Under the visionary leadership of Prof. Dasaad Mulijono, Bethsaida Hospital has emerged as a pioneering institution where modern medicine is harmonized with deeply rooted humanitarian values. The hospital's ethos is grounded in the active practice of love, empathy, kindness, forgiveness, patience, and loyalty—principles that permeate every level of care delivery. Firmly rejecting all forms of discrimination based on ethnicity, religion, or political affiliation, Bethsaida enforces strict policies to uphold a culture of inclusivity, compassion, and ethical integrity. More than a ceremonial vow, the Hippocratic Oath is embedded into the hospital's daily operations, forming the bedrock of its institutional identity. This

moral foundation has fostered the successful implementation of the hospital's groundbreaking WFPBD program, which addresses the multifactorial pathophysiology of coronary artery disease by targeting key metabolic and inflammatory pathways, ranging from obesity and insulin resistance to endothelial dysfunction and Western dietary excess. Clinical outcomes at Bethsaida have been transformative, featuring sustainable reductions in body mass index, reversal of hypertension without medication, consistently low LDL-C levels below 30 mg/dL, normalization of renal function in patients with chronic kidney disease, and superior glycaemic control in those with T2DM. When integrated with DCB angioplasty, this approach has driven restenosis rates to unprecedentedly low

levels (~2%). At the same time, imaging data reveal stabilization and regression of atherosclerotic plaques, challenging the conventional pharmacologic paradigm of chronic cardiovascular care.

Amid the global chaos of the COVID-19 pandemic, Prof. Mulijono's commitment to these principles was most vividly demonstrated. While others withdrew, he courageously advanced to the front lines as early as February 2020, treating over 3,500 high-risk patients with a novel WFPBD-based intervention, achieving survival without a single fatality. Even when the Indonesian Doctors Association permitted physicians above 50 to self-isolate in May 2020, Prof. Mulijono, then 55, refused to abandon his patients, anchored by an unshakable belief in the sanctity of his calling and the divine protection of his faith. Ironically, those who once discriminated against him chose to retreat. At the same time, he stood resolute as a living testament to the transformative power of holistic medicine grounded in ethical courage, scientific innovation, and unwavering spiritual conviction.

4. Solutions and Recommendations

Addressing these issues requires a multifaceted approach:

4.1. Transparent and Meritocratic Systems:

Implementing transparent recruitment and promotion systems based on merit, capability, and ethical standards.

4.2. Anti-discrimination Policies:

Establishing robust anti-discrimination and anti-corruption regulations with clear, enforceable penalties to discourage unethical practices.

4.3. Ethical Training and Accountability:

Reinforcing medical education with comprehensive ethics, empathy, and holistic patient care training. Regular audits and feedback mechanisms are in place to ensure adherence to ethical standards.

4.4. Promotion of Evidence-based Innovations:

Encouraging and incentivizing the adoption of validated health programs, such as WFPBD, through institutional support, training, and public education campaigns.

4.5. Utilization of Advanced AI and Robotic Technology:

Leveraging AI and robotic technologies to ensure unbiased, meritocratic recruitment, interviewing, and examination selection processes.

Establishing advisory and oversight collaboration with internationally recognized meritocratic healthcare systems, such as those in the USA and Australia, to reinforce transparency, impartiality, and fairness.

5. Conclusion

Healthcare systems compromised by corruption, nepotism, collusion, and discrimination are not merely inefficient—they are ethically bankrupt and structurally unsustainable. Such systems betray

the Hippocratic Oath, erode public trust, impair clinical outcomes, and contribute to significant economic leakage as patients seek inadequate care abroad for treatment. In contrast, Bethsaida Hospital is a living testament to what medicine can achieve when governed by moral clarity, meritocracy, and an unwavering commitment to holistic healing. Under the leadership of Prof. Dasaad Mulijono, Bethsaida has shown that transformative outcomes—once thought unattainable in conventional systems—are possible and replicable when ethical courage and evidence-based innovation are embraced.

The success of Bethsaida's WFPBD program, combined with advanced therapies like DCB angioplasty, proves that patient-centred, love-driven, and scientifically grounded care is the future of medicine. It is no longer acceptable for institutions to hide behind tradition or bureaucracy while lives are lost to preventable failures.

Urgent national reform is imperative. Governments, medical associations, and healthcare institutions must commit to dismantling systemic injustice and embracing transparent, AI-supported, meritocratic structures. Ethical integrity must be enforced, not encouraged, through policy, education, and oversight. By following models like Bethsaida, healthcare can return to its highest calling: to heal without bias, to serve with compassion, and to preserve life with excellence and equity.

References

1. Togioka, B., & Young, E. (2024). Diversity and discrimination in health care. *StatPearls*.
2. Williams, M. S., Myers, A. K., Finuf, K. D., Patel, V. H., Marrast, L. M., Pekmezaris, R., & Martinez, J. (2023). Black physicians' experiences with anti-Black racism in healthcare systems explored through an attraction-selection-attrition lens. *Journal of business and psychology*, 38(1), 75-88.
3. Webster, C. S., Taylor, S., Thomas, C., & Weller, J. M. (2022). Social bias, discrimination and inequity in healthcare: mechanisms, implications and recommendations. *BJA education*, 22(4), 131-137.
4. Ricks, T. N., Abbyad, C., & Polinard, E. (2022). Undoing racism and mitigating bias among healthcare professionals: lessons learned during a systematic review. *Journal of racial and ethnic health disparities*, 9(5), 1990-2000.
5. Walujono, A. (2014). The discrimination of the ethnic Chinese in Indonesia and perceptions of nationality.
6. Tyson, A. (2003). Realities Of Discrimination In Indonesia: The Case Of The Civil Service. *Jurnal Administrasi Publik*, 2(2).
7. Dhaneswara, N. (2023). Minority feelings: Chinese Ethnic in Indonesia. In *Proceedings of the 4th International Conference on Social Sciences, Humanities, and Arts* (Vol. 10).
8. Rikardi, A. A. (2023). The Role of Realistic Threats to Prejudice against Ethnic Chinese in Indonesia. *Madani Jurnal Politik Dan Sosial Kemasyarakatan*, 15(02), 310-321.
9. Rima, S. P. P., Bumantari, A. F., Nabillah, B. I., Malufti, C. N., Adhiguna, G., Hadianto, H., ... & Setiawan, Y. P. (2024). A Comprehensive Approach to Ending Bullying in Indonesia's

- Medical Residency Programs: A Policy Brief. *Acta Neurologica Indonesia*, 2(03).
10. Wahyuni, D., & Reswari, P. A. D. (2024). Efforts to prevent Bullying Against Students in the Specialist Medical Education Program. *Field of People's Welfare, INFO, a brief study of actual and strategic issues*, 16.
 11. Saleh, R. F. R., Sopardireza, A. F., Wijaya, A. R., Maharani, B. N., & Sari, S. M. Exploring The Perception and Potential of Bullying among First-Year Medical Students In Indonesia: A Qualitative Study. *Jurnal Pendidikan Kedokteran Indonesia: The Indonesian Journal of Medical Education*, 14(1), 32-43.
 12. Juwita, R. (2023). Understanding the Typology of Health Sector Corruption in Indonesia. *Indon. L. Rev.*, 13, 89.
 13. Kahleova, H., Levin, S., & Barnard, N. D. (2018). Vegetarian dietary patterns and cardiovascular disease. *Progress in cardiovascular diseases*, 61(1), 54-61.
 14. Caldwell, B., Esselstyn, C. B., Gendy, G., & Doyle, J. (2014). A way to reverse CAD. *J Fam Pract*, 63(7), 356-364b.
 15. Mehta, P., Tawfeeq, S., Padte, S., Sunasra, R., Desai, H., Surani, S., & Kashyap, R. (2023). Plant-based diet and its effect on coronary artery disease: A narrative review. *World Journal of Clinical Cases*, 11(20), 4752.
 16. Ornish, D., Scherwitz, L. W., Billings, J. H., Gould, K. L., Merritt, T. A., Sparler, S., ... & Brand, R. J. (1998). Intensive lifestyle changes for reversal of coronary heart disease. *Jama*, 280(23), 2001-2007.
 17. Satija, A., Bhupathiraju, S. N., Spiegelman, D., Chiuve, S. E., Manson, J. E., Willett, W., ... & Hu, F. B. (2017). Healthful and unhealthful plant-based diets and the risk of coronary heart disease in US adults. *Journal of the American college of cardiology*, 70(4), 411-422.
 18. Tusso, P., Stoll, S. R., & Li, W. W. (2015). A plant-based diet, atherogenesis, and coronary artery disease prevention. *The Permanente Journal*, 19(1), 62.
 19. Peña-Jorquera, H., Cid-Jofré, V., Landaeta-Díaz, L., Petermann-Rocha, F., Martorell, M., Zbinden-Foncea, H., ... & Cristi-Montero, C. (2023). Plant-based nutrition: Exploring health benefits for atherosclerosis, chronic diseases, and metabolic syndrome—A comprehensive review. *Nutrients*, 15(14), 3244.
 20. Babalola, F., Adesuyi, A., David, F., Kolajo, B. B. A., Urhi, A., Akinade, O., ... & UNEDU, O. R. (2022). A comprehensive review on the effects of vegetarian diets on coronary heart disease. *Cureus*, 14(10).
 21. Sikand, G., & Severson, T. (2020). Top 10 dietary strategies for atherosclerotic cardiovascular risk reduction. *American Journal of Preventive Cardiology*, 4, 100106.
 22. McMacken, M., & Shah, S. (2017). A plant-based diet for the prevention and treatment of type 2 diabetes. *Journal of geriatric cardiology: JGC*, 14(5), 342.
 23. Yang, X., Li, Y., Wang, C., Mao, Z., Chen, Y., Ren, P., ... & Li, L. (2021). Association of plant-based diet and type 2 diabetes mellitus in Chinese rural adults: The Henan Rural Cohort Study. *Journal of Diabetes Investigation*, 12(9), 1569-1576.
 24. Pollakova, D., Andreadi, A., Pacifici, F., Della-Morte, D., Lauro, D., & Tubili, C. (2021). The impact of vegan diet in the prevention and treatment of type 2 diabetes: a systematic review. *Nutrients*, 13(6), 2123.
 25. Jardine, M. A., Kahleova, H., Levin, S. M., Ali, Z., Trapp, C. B., & Barnard, N. D. (2021). Perspective: plant-based eating pattern for type 2 diabetes prevention and treatment: efficacy, mechanisms, and practical considerations. *Advances in Nutrition*, 12(6), 2045-2055.
 26. Ansari, P., Khan, J. T., Chowdhury, S., Reberio, A. D., Kumar, S., Seidel, V., ... & Flatt, P. R. (2024). Plant-based diets and phytochemicals in the management of diabetes mellitus and prevention of its complications: A review. *Nutrients*, 16(21), 3709.
 27. Barnard, N. D., Cohen, J., Jenkins, D. J., Turner-McGrievy, G., Gloede, L., Green, A., & Ferdowsian, H. (2009). A low-fat vegan diet and a conventional diabetes diet in the treatment of type 2 diabetes: a randomized, controlled, 74-wk clinical trial. *The American journal of clinical nutrition*, 89(5), 1588S-1596S.
 28. Guest, N. S., Raj, S., Landry, M. J., Mangels, A. R., Pawlak, R., Senkus, K. E., ... & Rozga, M. (2024). Vegetarian and vegan dietary patterns to treat adult type 2 diabetes: A systematic review and meta-analysis of randomized Controlled Trials. *Advances in Nutrition*, 15(10), 100294.
 29. Panigrahi, G., Goodwin, S. M., Staffier, K. L., & Karlsen, M. (2023). Remission of type 2 diabetes after treatment with a high-fiber, low-fat, plant-predominant diet intervention: a case series. *American Journal of Lifestyle Medicine*, 17(6), 839-846.
 30. Hardt, L., Mahamat-Saleh, Y., Aune, D., & Schlesinger, S. (2022). Plant-based diets and cancer prognosis: a review of recent research. *Current Nutrition Reports*, 11(4), 695-716.
 31. Cheng, E., Ou, F. S., Gatten, C., Ma, C., Venook, A. P., Lenz, H. J., ... & Meyerhardt, J. A. (2025). Plant-based diet and survival among patients with metastatic colorectal cancer. *JNCI: Journal of the National Cancer Institute*, 117(1), 169-179.
 32. Loeb, S., Hua, Q., Bauer, S. R., Kenfield, S. A., Morgans, A. K., Chan, J. M., ... & Mucci, L. A. (2024). Plant-based diet associated with better quality of life in prostate cancer survivors. *Cancer*, 130(9), 1618-1628.
 33. Madigan, M., & Karhu, E. (2018). The role of plant-based nutrition in cancer prevention. *Journal of Unexplored Medical Data*, 3, N-A.
 34. Liu, V. N., Van Blarigan, E. L., Zhang, L., Graff, R. E., Loeb, S., Langlais, C. S., ... & Kenfield, S. A. (2024). Plant-based diets and disease progression in men with prostate cancer. *JAMA Network Open*, 7(5), e249053-e249053.
 35. Campbell, T. M., Campbell, E. K., Culakova, E., Blanchard, L. M., Wixom, N., Guido, J. J., ... & Peppone, L. J. (2024). A whole-food, plant-based randomized controlled trial in metastatic breast cancer: weight, cardiometabolic, and hormonal outcomes. *Breast Cancer Research and Treatment*, 205(2), 257-266.
 36. Najjar, R. S., & Feresin, R. G. (2019). Plant-based diets in the reduction of body fat: physiological effects and biochemical insights. *Nutrients*, 11(11), 2712.
 37. Greger, M. (2020). A whole food plant-based diet is effective

- for weight loss: The evidence. *American journal of lifestyle medicine*, 14(5), 500-510.
38. Ahmad, S. R. (2022). Plant-based diet for obesity treatment. *Frontiers in nutrition*, 9, 952553.
 39. Remde, A., DeTurk, S. N., Almardini, A., Steiner, L., & Wojda, T. (2022). Plant-predominant eating patterns—how effective are they for treating obesity and related cardiometabolic health outcomes?—a systematic review. *Nutrition reviews*, 80(5), 1094-1104.
 40. Bassin, S. R., De Carvalho, J. F., & Gulati, M. (2024). A review of plant-based diets for obesity management. *Endocrine Practice*, 30(8), 779-789.
 41. Jakše, B., Jakše, B., Pinter, S., Pajek, J., & Fidler Mis, N. (2022). Whole-food plant-based lifestyle program and decreased obesity. *American Journal of Lifestyle Medicine*, 16(3), 260-270.
 42. Ivanova, S., Delattre, C., Karcheva-Bahchevanska, D., Benbasat, N., Nalbantova, V., & Ivanov, K. (2021). Plant-based diet as a strategy for weight control. *Foods*, 10(12), 3052.
 43. Campbell, E. K., Fidahusain, M., & Campbell II, T. M. (2019). Evaluation of an eight-week whole-food plant-based lifestyle modification program. *Nutrients*, 11(9), 2068.
 44. Bolori, P., Setaysh, L., Rasaei, N., Jarrahi, F., & saeid Yekaninejad, M. (2019). Adherence to a healthy plant diet may reduce inflammatory factors in obese and overweight women—a cross-sectional study. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, 13(4), 2795-2802.
 45. Chen, Z., Schoufour, J. D., Rivadeneira, F., Lamballais, S., Ikram, M. A., Franco, O. H., & Voortman, T. (2019). Plant-based diet and adiposity over time in a middle-aged and elderly population: the Rotterdam Study. *Epidemiology*, 30(2), 303-310.
 46. Brown, C. E., Jackson, S. Y., Marshall, A. R., Pytel, C. C., Cueva, K. L., Doll, K. M., & Young, B. A. (2024). Discriminatory healthcare experiences and medical mistrust in patients with serious illness. *Journal of pain and symptom management*, 67(4), 317-326.
 47. Suen, K., Shrestha, S., Osman, S., & Paudyal, V. (2025). Association Between Patient Race/Ethnicity, Health Literacy, Socio-Economic Status, and Incidence of Medication Errors: A Systematic Review. *Journal of Racial and Ethnic Health Disparities*, 1-12.
 48. Zimmer, Z., Rojo, F., Ofstedal, M. B., Chiu, C. T., Saito, Y., & Jagger, C. (2019). Religiosity and health: A global comparative study. *SSM-population health*, 7, 100322.
 49. Bergin J. Left Behind. Corruption in Education and Health Services in Africa. 2024. ISBN: 978-3-96076-257-7.
 50. National Academies of Sciences, Engineering, and Medicine. (2018). Health and Medicine Division; Board on Health Care Services; Board on Global Health; Committee on Improving the Quality of Health Care Globally. Crossing the Global Quality Chasm: Improving Health Care Worldwide. *Crossing the global quality chasm: improving health care worldwide*.
 51. García, P. J. (2019). Corruption in global health: the open secret. *The Lancet*, 394(10214), 2119-2124.
 52. Glynn, E. H. (2022). Corruption in the health sector: A problem in need of a systems-thinking approach. *Frontiers in public health*, 10, 910073.

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