Medicine & Clinical Science

Perspective Article

The Cure We Refuse: Unmasking the Resistance Against Whole-Food Plant-Based Diets in Modern Medicine

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- Received Date: 03 June 2025
- Accepted Date: 09 June 2025
- Publication Date: 12 June 2025

Keywords

Whole-Food Plant-Based Diet, Lifestyle Medicine, Preventive Health, Chronic Disease Reversal, Cultural Barriers, Medical Ethics, Bethsaida Hospital, Prof. Dasaad Mulijono

Abstract

Despite decades of compelling scientific evidence, Whole-Food Plant-Based Diets (WFPBDs) remain one of the most underutilized, misunderstood, and undervalued medical interventions in modern healthcare. This paper unpacks the disturbing paradox of why a clinically validated, cost-effective, and safe dietary strategy capable of reversing chronic diseases—including coronary artery disease (CAD), type 2 diabetes mellitus (T2DM), hypertension, obesity, kidney dysfunction, and even early cancers—continues to be marginalized. Drawing on nearly seven years of clinical experience at Bethsaida Hospital under the visionary leadership of Prof. Dasaad Mulijono in Indonesia, we present transformative real-world outcomes in over 6,000 patients, including zero mortality among high-risk elderly COVID-19 cases treated with WFPBD and lifestyle medicine. The discussion explores why the medical community still resists WFPBDs: cultural dogmas, food addiction, economic incentives, insufficient medical education, and systemic bias in research funding. We argue that this resistance is no longer rooted in scientific uncertainty, but in deeply entrenched institutional and psychological barriers. In a world where invasive procedures are glorified and preventive solutions dismissed, embracing WFPBDs is not only a medical necessity but a moral obligation. If we fail to act now, we are not just neglecting a dietary intervention—we are denying patients the right to live.

Introduction

In an age where chronic diseases have eclipsed infectious diseases as the leading cause of global morbidity and mortality [1-3], the medical profession finds itself in a paradoxical crisis: the very cure that could reverse this trend—WFPBDs—remains marginalized, dismissed, or misunderstood. Despite a vast body of clinical, epidemiological, and mechanistic evidence showing that WFPBDs can prevent, halt, and even reverse CAD, T2DM, obesity, hypertension, kidney dysfunction, and inflammatory conditions, the adoption of this approach within modern medicine remains disturbingly rare [4-7].

The question is no longer whether plant-based diets work—they do—but why we, as a society and a profession, continue to ignore them.

This article explores that dissonance. Drawing on the transformative clinical outcomes achieved at Bethsaida Hospital in Indonesia under the visionary leadership of Professor Dasaad Mulijono, we present real-world evidence from over 6,000 patients, many of whom were refractory to conventional treatments. From coronary regression to the unprecedented survival of high-risk elderly patients during the COVID-19 pandemic without hospitalization or mortality, the data are not merely compelling—they are paradigm-shifting. And yet, these outcomes remain largely unrecognized, not for lack of rigor, but due to deeply rooted barriers that medicine has yet to confront.

What prevents the medical community from embracing such an accessible and powerful intervention? The resistance is multifactorial, anchored in cultural identity, psychological addiction to unhealthy foods, commercial corruption, inadequate medical training, and a healthcare economy built on intervention rather than prevention. This paper contends that the failure to adopt WFPBDs is no longer a scientific oversight but an ethical failure. In an era where evidence-based practice is the gold standard, the continued neglect of WFPBDs challenges not only our clinical judgment but also our moral integrity.

The cure is not in the future. It exists now. But until we unmask the resistance, we will remain complicit in a system that treats disease rather than prevents it—and profits from suffering rather than healing.

Citation: Mulijono D. The Cure We Refuse: Unmasking the Resistance Against Whole-Food Plant-Based Diets in Modern Mediciney. Med Clin Sci. 2025;7(3):046.

The Author's Journey: From Skepticism to Transformation

Initially sceptical, I embraced the WFPBD approach only after being diagnosed with coronary calcification and intermediate LAD stenosis. Traditional interventions posed unacceptable risks due to my peptic ulcer condition. Turning to a strict WFPBD, I experienced a dramatic regression in coronary blockage and reduction in calcium scores over five years [8]. Furthermore, during the COVID-19 pandemic, over 3,500 high-risk elderly patients under my care, including myself, adopted WFPBDs and nutritional supplementation, and survived without hospitalization or mortality [9-11]. These clinical results were too compelling to ignore and marked a turning point in my practice philosophy.

Clinical Outcomes at Bethsaida Cardiac Centre

We are pleased to share the remarkable outcomes achieved at the Cardiology Centre of Bethsaida Hospital in Tangerang, Indonesia, where we have implemented a WFPBD as part of our standard cardiac care for nearly seven years. This pioneering program represents the first of its kind in Indonesia, integrating evidence-based nutritional therapy into routine cardiovascular practice.

Despite the compelling clinical outcomes, the recognition of our work has been modest both locally and internationally, mainly due to systemic limitations in research infrastructure, funding, and prevailing skepticism within the medical community. However, the transformational impact on patient health has been undeniable.

To date, over 6,000 patients have participated in the plant-based intervention program at Bethsaida Hospital. The majority were middle-aged to elderly males with established cardiovascular disease, many of whom were refractory to standard pharmacological therapies. Patients were supported by a multidisciplinary team that provided nutritional counselling, AI-assisted educational modules, and peer-led support. Clinical monitoring included laboratory markers, coronary CT angiography, and echocardiography.

Key clinical outcomes include [12-23]:

1. **Hypertension Reversal Without Medications** – Patients achieved normotensive readings without pharmacologic support through diets rich in potassium, magnesium, and nitric oxide (NO)-enhancing greens while avoiding sodium-rich animal products.
2. **Diabetes Management Without Insulin** – T2DM patients successfully discontinued insulin and minimized oral agents while maintaining glycaemic control, with significant HbA1c reductions and improved energy levels.
3. **LDL Cholesterol Reduction Without PCSK9 Inhibitors** – Profound reductions in LDL-C levels were achieved with PBD and statin/ezetimibe therapy, eliminating the need for expensive PCSK9 injection.
4. **Sustainable Weight Loss** – Overweight and obese patients reached ideal BMI (20–22) without calorie restriction, driven by high satiety and nutrient-dense whole foods.
5. **Renal Function Restoration** – In mild-to-moderate chronic kidney disease (CKD), improvements in GFR and serum creatinine were recorded, delaying or avoiding dialysis.
6. **Heart Failure Symptom Improvement** – HFrEF patients experienced improved ejection fraction and functional status with WFPBD in addition to standard therapy.
7. **CAD Regression and Exceptionally Low Restenosis** – Angiographic regression and a 2% restenosis rate following Drug-Coated Balloon (DCB) angioplasty underscore the synergistic impact of lesion preparation and lifestyle change.
8. **Modulation of Other Inflammatory Conditions** – Patients with autoimmune diseases, psoriasis, and early cancers reported symptom resolution or disease stabilization under strict PBD adherence.
9. **COVID-19 Outcomes and Immune Resilience** – During the height of the COVID-19 pandemic, our WFPBD program played a crucial role in the survival and recovery of thousands of elderly patients with multiple comorbidities. Remarkably, none of these patients required ICU admission or succumbed to the virus. This unprecedented outcome underscores the substantial potential of WFPBDs to enhance immune function and resilience against viral respiratory infections. It is a public health achievement that demands serious attention as we prepare for future pandemics.

These real-world results offer compelling evidence that WFPBD is not only clinically viable but profoundly impactful. Through this program, Bethsaida aims to contribute a meaningful voice to the global dialogue on nutrition in cardiovascular medicine and inspire broader, more courageous adoption of this life-saving approach.

Barriers to Plant-Based Diet Adoption

Despite the vast body of scientific evidence demonstrating the profound benefits of WFPBD in preventing and reversing chronic inflammatory diseases, widespread resistance to their adoption persists, not only among the general public but also within the medical community itself. This reluctance stems from a complex interplay of cultural norms, food addiction, lack of education and training in nutrition, economic interests tied to the pharmaceutical and food industries, and institutional inertia. In this section, we systematically outline the key factors

contributing to this resistance and explore the underlying psychological, societal, and structural barriers that continue to hinder the full integration of WFPBD into mainstream healthcare practice [24-32].

Cultural and Religious Perceptions

Across many societies, food is intricately linked to religious values, cultural identity, and socioeconomic status. Luxury foods, often unhealthy, symbolize success, making healthy diets seem less desirable. Culinary tradition becomes a roadblock to health.

Psychological Dependency and Pleasure Traps

Unhealthy foods stimulate reward centres in the brain, releasing serotonin, dopamine, and endorphins. These pleasure responses create psychological addictions, making healthy food appear bland or undesirable.

The Pleasure-Pain Paradox

While WFPBDs are perceived as restrictive and painful, unhealthy diets are pleasurable—even if they lead to amputations, heart surgeries, or cancer treatments. People often prefer immediate pleasure over long-term well-being, accepting severe consequences without reconsidering dietary choices.

Medical Education Deficiency

More than 70% of medical students receive less than 2 hours of nutritional education. Consequently, most physicians are not equipped or motivated to recommend dietary interventions. Curative medicine takes precedence over preventive education.

Commercial and Industry Influence

The influence of the food and pharmaceutical industries on medical research and education is substantial. Funded studies may distort dietary science, promoting unhealthy products while undermining the credibility of WFPBDs.

Economic Incentives in Healthcare

Curative procedures, such as stenting, generate more revenue than preventive measures. Doctors and hospitals may experience financial disincentives when patients recover through lifestyle changes. This undermines Hippocratic ideals in favour of profitability.

Policy and Systemic Inertia

Though recent trials like COURAGE, ORBITA, and ISCHAEMIA suggest that medical therapy equals PCI for stable angina, invasive approaches still dominate [33-40]. The government's reluctance to fund lifestyle interventions slows progress.

Desperation as a Catalyst

Only in moments of crisis, such as during COVID-19 or personal illness, do patients and physicians turn to PBDs. Unfortunately, desperation is not a scalable health strategy.

Misconceptions About Extremism

Esselstyn once remarked, “Some people think a WFPBD is extreme. Yet half a million people a year have their chests opened.” The cultural normalization of disease makes surgery more acceptable, while diet changes are viewed as extreme.

Nutritional Deficiency Concerns

Critics argue that PBDs may lack vitamin B12, omega-3, iron, or zinc. However, omnivorous diets often lack fibre, NO precursors, and antioxidants while promoting systemic inflammation. Both diets require awareness; neither is perfect by default.

Solutions: Bridging the Divide Between Knowledge and Practice

Reforming Medical Education: Nutrition must be integrated into curricula, and lifestyle medicine should be a core component of all specialties [41-43].

- **Incentivizing Prevention:** Governments and insurance providers should financially reward disease reversal and prevention through WFPBDs.
- **Ethical Accountability:** Physicians must revisit the Hippocratic Oath. Preventing suffering through WFPBDs should be seen as an ethical imperative, not a fringe ideology [44-46].
- **Public Education Campaigns:** Cultural and psychological resistance can be countered through widespread campaigns, testimonials, and community programs showcasing the success of WFPBDs.
- **Balanced Nutritional Planning:** While advocating for WFPBDs, clinicians must also ensure that patients receive adequate nutrients through a combination of food and supplementation [47-49].

Discussion

The evidence presented in this paper demonstrates unequivocally that WFPBDs have the potential not merely to manage but to reverse numerous chronic diseases, dramatically reshaping patient outcomes. The transformational clinical experiences at Bethsaida Hospital, under the guidance of Prof. Dasaad Mulijono, provide robust real-world validation, showcasing improvements in hypertension, T2DM, dyslipidaemia, CKD, CAD, heart failure, and even autoimmune and inflammatory conditions. The successful management of high-risk elderly COVID-19 patients with zero mortality underscores the diet’s immense potential in bolstering immune resilience and managing systemic inflammation, pivotal factors in chronic and acute illnesses.

Despite these robust clinical outcomes, resistance to adopting WFPBDs remains widespread, deeply entrenched in multifaceted societal and systemic barriers. Cultural perceptions and deeply ingrained dietary traditions often dictate nutritional choices, associating unhealthy, animal-based foods with prestige and success, while erroneously perceiving WFPBDs as restrictive or unappealing. Furthermore, psychological factors, particularly food addiction and pleasure-seeking behaviour reinforced by brain chemistry, exacerbate resistance to dietary changes, creating significant hurdles even among informed individuals.

Within the healthcare sector, systemic inertia persists due to inadequate medical education. Nutritional training remains underrepresented, leaving physicians ill-equipped to recommend dietary interventions confidently. Medical curricula emphasize pharmaceutical and procedural interventions over lifestyle medicine, perpetuating reliance on symptomatic management rather than disease prevention and reversal. Commercial influences further compound this issue, as food and pharmaceutical industries, driven by profit motives, shape clinical guidelines, research priorities, and public health messaging, creating conflicts of interest that diminish enthusiasm for cost-effective nutritional interventions.

Economic incentives heavily favour invasive and pharmaceutical treatments, creating financial disincentives for preventive measures such as WFPBDs. The healthcare economy, designed to profit from chronic disease management rather than

prevention, inadvertently discourages the adoption of lifestyle changes that have been proven to reverse disease progression. Despite landmark studies such as COURAGE, ORBITA, and ISCHAEMIA demonstrating equivalence or superiority of medical management and lifestyle interventions to invasive procedures, entrenched financial interests and systemic biases continue to prioritize high-revenue interventions.

However, the COVID-19 pandemic exposed the vulnerability of traditional medical paradigms, highlighting the need for preventive approaches to enhance population health resilience. The remarkable clinical successes at Bethsaida Hospital during the pandemic underscore the critical importance of integrating WFPBDs into public health strategies, highlighting their capacity to significantly mitigate morbidity and mortality even in the face of unprecedented health crises.

To overcome these entrenched barriers, transformative solutions are required. Foremost among these is a fundamental reform of medical education to integrate comprehensive nutrition and lifestyle medicine training, equipping future healthcare providers with evidence-based nutritional strategies. Policy interventions must prioritize preventive healthcare measures, financially incentivizing disease reversal through lifestyle interventions and penalizing overreliance on invasive and pharmaceutical treatments. Ethical accountability within the medical profession should be reinforced, with a focus on prevention as a moral imperative aligned with the principles of the Hippocratic Oath.

Furthermore, broad public education campaigns are essential to address cultural and psychological resistance, leveraging compelling patient testimonials, community success stories, and evidence-based messaging to shift societal perceptions positively toward plant-based nutrition. Ensuring balanced nutritional planning, clinicians must proactively address nutrient concerns associated with WFPBDs, thereby eliminating misconceptions and building patient confidence in their dietary choices.

Conclusions

Resistance to WFPBDs is no longer justifiable on scientific grounds. The robust clinical evidence and real-world outcomes presented from Bethsaida Hospital affirm the transformative potential of this dietary approach in reversing chronic diseases and enhancing overall health resilience. However, profound societal, institutional, and psychological barriers continue to impede widespread adoption.

It is incumbent upon healthcare professionals, policymakers, educators, and communities to dismantle these barriers through concerted action. The moral and ethical imperatives for embracing WFPBDs are compelling and urgent. The current medical paradigm, which focuses excessively on profitable interventions rather than preventive, lifestyle-oriented medicine, must undergo a radical transformation.

The journey forward requires collective courage, systemic reform, and an unwavering commitment to evidence-based practice. The cure exists within reach, embodied in simple dietary choices that can profoundly heal and transform lives. Let us choose to embrace this cure now, not out of desperation, but from informed, ethical commitment to genuine healthcare innovation. In doing so, we move closer to a future where chronic disease is no longer an inevitability, but a preventable reality.

Author Contributions

D.M.; Conceptualization, writing, review, and editing.

Funding

This research received no external funding.

Institutional Review Board Statement

Not applicable.

Informed Consent Statement

Not applicable.

Data Availability Statement

Data are contained within the article.

Conflict of Interest

The authors declare no conflict of interest.

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