Review

# STRENGTHENING CONSERVATIVE MUSCULOSKELETAL CARE IN VIETNAM: LESSONS FROM JUDO-SEIFUKU FOR FIXATION, FUNCTIONAL RECOVERY, AND MEDICAL EDUCATION

## Nâng cao hiệu quả điều trị bảo tồn các bệnh lý về cơ xương khớp tại Việt Nam: Bài học từ Judo trị liệu (Judo-Seifuku) trong kỹ thuật cố định, phục hồi chức năng và đào tạo y khoa

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**ABSTRACT**

**Objectives:** This narrative review examines how conservative musculoskeletal care can be strengthened within Vietnam's existing health system and how the Japanese practice of Judo-Seifuku—conceptualized as an integrated treatment model rather than a profession to be imported—could contribute to this goal. **Methods:** We synthesized recent literature on the evidence supporting non-operative management of common musculoskeletal injuries, the role of functional recovery as an endpoint of conservative care, the economic and health-system advantages, and the context of the Vietnamese health system and traditional medicine. We then examined Judo-Seifuku as a model integrating reduction, fixation, and aftercare into a continuous treatment process and considered how its principles might inform the training of Vietnam's existing clinicians. **Results:** Conservative management is an evidence-based treatment strategy rather than merely a fallback when surgery is unavailable, and structural healing and functional recovery are complementary treatment goals. Effective conservative care for common musculoskeletal injuries involves the coordinated use of reduction when indicated, appropriate fixation, clinical monitoring, and progressive functional recovery. The Judo-Seifuku model integrates these elements into a continuous treatment process encompassing reduction, fixation, and aftercare. **Conclusions:** Strengthening conservative musculoskeletal care in Vietnam need not involve importing a foreign profession. Rather, there is an opportunity to enhance competence among clinicians working in orthopedics, rehabilitation, primary care, family medicine, and traditional medicine. The distinctive contribution of Judo-Seifuku lies in its integration of reduction, fixation, and aftercare into a continuous therapeutic process, with fixation serving as an active bridge between structural stabilization and progressive functional recovery. When adapted to local professional roles, regulations, and health-system needs and subjected to prospective evaluation, these principles may provide a useful framework for education and clinical practice.

**Keywords:** conservative musculoskeletal care; musculoskeletal fixation; musculoskeletal rehabilitation; Judo-Seifuku therapy; Vietnam health system; clinical competency training; orthopedic workforce development.

**TÓM TẮT**

**Mục tiêu:** Bài viết này giải thích cách thức tăng cường chăm sóc bảo tồn cơ xương khớp trong hệ thống y tế hiện tại của Việt Nam và làm thế nào phương pháp Judo-Seifuku của Nhật Bản —

được khái niệm hóa như một mô hình điều trị tích hợp thay vì một giải pháp bổ sung — có thể đóng góp vào mục tiêu này. **Phương pháp:** Chúng tôi đã tổng hợp các tài liệu gần đây về bằng chứng ủng hộ việc chăm sóc bảo tồn đối với các chấn thương cơ xương khớp phổ biến, vai trò của phục hồi chức năng như một phương pháp mấu chốt trong giai đoạn cuối của chăm sóc bảo tồn, các lợi thế về kinh tế và hệ thống y tế, cũng như bối cảnh của hệ thống y tế và y học cổ truyền Việt Nam. Sau đó, chúng tôi xem xét Judo-Seifuku như một mô hình tích hợp việc nắn chỉnh, cố định và chăm sóc sau điều trị thành một quá trình điều trị liên tục và xem xét cách các nguyên tắc của nó có thể cung cấp thông tin cho việc đào tạo các bác sĩ lâm sàng hiện tại của Việt Nam. **Kết quả:** chăm sóc bảo tồn là một chiến lược điều trị dựa trên bằng chứng chứ không chỉ đơn thuần là một phương án dự phòng khi không thể phẫu thuật, trong đó việc chữa lành cấu trúc và phục hồi chức năng là các mục tiêu điều trị bổ sung cho nhau. Chăm sóc bảo tồn hiệu quả cho các chấn thương cơ xương khớp phổ biến liên quan đến việc phối hợp sử dụng nắn chỉnh khi có chỉ định, cố định phù hợp, theo dõi lâm sàng và phục hồi chức năng theo tiến triển. Mô hình Judo-Seifuku tích hợp các yếu tố này vào một quá trình điều trị liên tục bao gồm nắn chỉnh, cố định và chăm sóc sau điều trị. **Kết luận:** Việc tăng cường chăm sóc, bảo tồn cơ xương khớp tại Việt Nam không nhất thiết phải học hỏi một chuyên môn khác từ nước ngoài. Thay vào đó, đây là cơ hội để nâng cao năng lực cho các bác sĩ lâm sàng làm việc trong lĩnh vực chấn thương chỉnh hình, phục hồi chức năng, chăm sóc ban đầu, y học gia đình và y học cổ truyền. Đóng góp đặc biệt của Judo-Seifuku nằm ở việc tích hợp nắn chỉnh, cố định và chăm sóc sau điều trị vào một quá trình trị liệu liên tục, trong đó sự cố định đóng vai trò như một cầu nối tích cực giữa ổn định cấu trúc và phục hồi chức năng theo từng giai đoạn. Khi được điều chỉnh cho phù hợp với vai trò chuyên môn, quy định và nhu cầu của hệ thống y tế địa phương và được đánh giá tiến cứu, các nguyên tắc này có thể cung cấp một khuôn khổ hữu ích cho giáo dục và thực hành lâm sàng.

**Từ khóa:** chăm sóc bảo tồn cơ xương khớp; cố định cơ xương khớp; phục hồi chức năng cơ xương khớp; liệu pháp Judo-Seifuku; hệ thống y tế Việt Nam; đào tạo năng lực lâm sàng; phát triển nhân lực chấn thương chỉnh hình.

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## I. INTRODUCTION

Musculoskeletal injuries are among the most common reasons for seeking medical care and impose a substantial and increasing burden of disability worldwide. This burden falls disproportionately on low- and middle-income countries, where fractures and other musculoskeletal injuries account for most injury-related disability but treatment capacity is most limited.[1,2] Specialist orthopedic and surgical services are scarce and unevenly distributed. In many settings, most of the population lacks reliable access to timely operative care, and fellowship-trained orthopedic traumatologists are scarce.[2,3] Vietnam faces similar pressures as it continues to develop and integrate its health system.

One underused response is to strengthen non-operative, conservative management. A substantial proportion of common fractures and soft-tissue injuries can be treated safely and effectively without surgery, provided that they are accurately reduced, appropriately supported, and monitored throughout functional recovery. Conservative care requires fewer material and human resources than operative fixation and avoids the risks and costs associated with anesthesia and surgery.

Strengthening this form of care is therefore an efficient way to expand access to musculoskeletal treatment.

This review examines that opportunity through a specific lens. The Japanese practice of Judo-Seifuku offers a mature, organized model of conservative musculoskeletal care that integrates reduction, fixation, and aftercare into a continuous treatment process. Although developed primarily for routine clinical care, aspects of this integrated approach have also been applied in disaster settings in Japan, as briefly discussed below. This review does not advocate importing the Japanese profession or its licensing system into Vietnam. Rather, it examines whether the concepts underlying the model's effectiveness, particularly fixation as an active therapeutic phase and functional recovery as the true endpoint of treatment, could be integrated into the education and practice of Vietnam's existing clinicians.

Accordingly, this review has four objectives: to establish conservative management as an evidence-based treatment strategy in its own right; to clarify that conservative care aims to achieve both structural healing and functional recovery across the full spectrum of musculoskeletal injuries; to present the integrated reduction–fixation–aftercare model, with particular attention to fixation, as a source of transferable clinical concepts; and to consider how these concepts might strengthen competence in conservative musculoskeletal care across Vietnam's existing medical workforce without creating a new occupational category.

## II. THE CASE FOR STRENGTHENING CONSERVATIVE MUSCULOSKELETAL CARE

### 1. Conservative management as an evidence-based treatment strategy

Conservative management is frequently framed, albeit implicitly, as an alternative used when surgery is unavailable. This framing is misleading. For many musculoskeletal injuries, non-operative treatment is a primary, evidence-based option that achieves outcomes equivalent to those of surgery in appropriately selected patients while avoiding operative risks and costs. The clinically important questions are therefore not merely whether a facility can provide surgery, but whether conservative treatment is indicated for a particular injury and whether the conditions required for its success are present. From this perspective, conservative care is not a concession to scarcity but a deliberate treatment strategy. Its fuller use is limited less by the evidence than by workforce capability and by how the approach is taught.

### 2. Evidence supporting conservative treatment of common injuries

Substantial evidence supports non-operative treatment of common injuries. For distal radius fractures, which are among the most frequent fractures encountered by health systems, closed reduction followed by cast immobilization remains a standard and effective conservative approach. Systematic reviews of randomized trials have focused on refining the immobilization technique and duration rather than questioning the appropriateness of conservative treatment itself.[4] For pediatric supracondylar humeral fractures of

intermediate severity, contemporary reviews report that non-operative management involving closed reduction and casting succeeds in approximately 70–90 percent of carefully selected cases. Functional outcomes may be comparable to those of surgery when alignment is maintained and follow-up is sufficiently close to detect any loss of reduction.[5] Selected vertebral compression and burst fractures have similarly been managed safely and effectively through closed reduction and casting, with favorable functional and radiographic outcomes.[6]

Two themes recur throughout this literature. First, conservative treatment is appropriate for a broad range of injuries when cases are correctly selected. Second, its success is conditional: it depends on accurate reduction, appropriate support, and structured follow-up, with clear provision for escalation to surgery if conservative treatment fails.

**3. Functional recovery across musculoskeletal injuries**

Conservative management extends well beyond fractures, and its purpose extends beyond bony union. Dislocations, sprains, strains, contusions, and other soft-tissue injuries account for a substantial proportion of routine musculoskeletal presentations. For these injuries, the relevant outcome is rarely radiographic. Outcomes important to patients include pain relief, range of motion, muscle strength, return to activity and work, and participation in daily life. When assessed against these outcomes, structural repair is necessary but insufficient.

This distinction is clearest when reduction alone is plainly inadequate. In a joint dislocation, relocating the joint restores alignment but does not, by itself, address the associated capsular and ligamentous injuries, muscular inhibition, or loss of proprioception. Without protected, progressive rehabilitation, instability and stiffness may persist. In a sprain, the central task is to balance tissue protection with the prevention of deconditioning, stiffness, and functional loss caused by immobilization.

A common principle applies across these injuries: conservative management is best understood not as a period of waiting for tissue to heal, but as a process in which structural healing and functional recovery are pursued as complementary treatment goals. Treatment that achieves union or relocation but results in avoidable loss of motion, strength, or confidence is only partly successful. This shift from a structural endpoint to a combined structural and functional endpoint distinguishes a mature model of conservative care and provides the standard against which any approach, including that discussed below, should be assessed.

**4. Economic and health-system advantages of conservative care**

Strengthening conservative care also offers system-level advantages that are particularly relevant to Vietnam. Non-operative treatment is typically less costly than surgery. It reduces hospital admissions and demand for operating theatres, lessens dependence on implants and other consumables whose availability and cost may be limiting, and reduces reliance on scarce specialist surgeons for injuries that do not require operative treatment. Each of these

effects alleviates a constraint acutely experienced by health systems with developing surgical and orthopedic capacity. Directing appropriately selected injuries towards well-conducted conservative treatment frees operative capacity for cases that genuinely require surgery and makes musculoskeletal care more accessible in first-contact and community settings. However, these advantages are contingent on the quality of care: cost reductions achieved at the expense of functional outcomes do not constitute genuine savings.

**5. Requirements for successful conservative management**

Conservative management is therefore not a single intervention but a system of interconnected requirements. Four are essential. When indicated, reduction restores anatomical alignment. Fixation maintains this alignment and protects healing tissue. Monitoring enables the timely detection of complications and positional loss. Structured functional recovery restores movement, strength, and participation. These requirements map onto, rather than compete with, the three-phase reduction–fixation–aftercare structure: reduction, fixation, and aftercare are the sequential phases of treatment, whereas monitoring and functional recovery are activities embedded within them—monitoring spans the fixation and aftercare phases, and functional recovery begins during fixation and continues through aftercare.

Weakness in any of these components undermines the others: precise reduction is wasted if fixation fails; fixation is unsafe without monitoring; and even a well-united fracture yields a poor result if functional recovery is neglected. In particular, immobilization alone, when fixation is regarded merely as holding a body part still, is insufficient to achieve a favorable outcome and may itself cause the stiffness and deconditioning that conservative care seeks to prevent. The practical challenge is therefore not to perform each step in isolation but to deliver all four as an integrated, continuous process. The Japanese model of Judo-Seifuku articulates this integration precisely and is the focus of the following discussion.

## III. CONSERVATIVE MUSCULOSKELETAL CARE IN THE VIETNAMESE HEALTH SYSTEM

**1. Vietnam-specific needs for conservative musculoskeletal care**

Strengthening conservative musculoskeletal care is particularly important in Vietnam due to the geographic distribution of its clinical workforce. Physicians and specialists are heavily concentrated in major cities, notably Hanoi and Ho Chi Minh City, while rural, remote, and mountainous areas face persistent shortages. Most doctors work at provincial or higher-level facilities, whereas commune-level services, which are closest to rural communities, are chronically under-resourced.[7,8] Because musculoskeletal injuries commonly present in first-contact and community settings, this maldistribution means that the populations most likely to sustain them may have the least access to clinicians able to provide appropriate care. Competence in conservative musculoskeletal care, confined to

a small number of urban specialists, cannot meet a need that arises across the country.

The structure of care compounds this problem. Vietnamese health care is organized across central, provincial, district, and commune levels, but service delivery remains heavily hospital-centered. Patients frequently bypass primary care facilities and seek treatment directly at crowded provincial and central hospitals, partly because higher-level facilities are perceived to provide better-quality care.[7] For many common musculoskeletal injuries that can be appropriately treated without hospital resources, this pattern is inefficient: it concentrates demand where capacity is most constrained and leaves first-contact and community settings underused. Strengthening competence in conservative musculoskeletal care at lower levels would bring appropriate treatment closer to patients and help redirect care away from overburdened hospitals.

Cost considerations support the same conclusion. Out-of-pocket payments account for approximately 40 percent of current health expenditure in Vietnam over the period 2012–2022—a proportion close to that contributed by the government and well above the 15–20 percent range associated with adequate financial protection—placing a substantial burden on households.[7,9] Because non-operative treatment is typically less costly than surgery and can often be delivered outside hospitals, expanding well-conducted conservative management offers both clinical and financial benefits by reducing reliance on expensive hospital-based and operative care for injuries that do not require it. Delivering such care safely outside the hospital depends on appropriate case selection and on the necessary supports being in place—initial clinical and, where indicated, radiographic assessment; adequately trained providers; structured monitoring; and clear referral pathways. In Japan, for example, fractures and dislocations are managed by judo therapists in outpatient clinics under the agreement of a physician, so that each case is medically assessed before conservative care continues outside the hospital. Taken together, the geographical distribution of the workforce, the hospital-centered structure of service delivery, and the financial burden of care provide a specifically Vietnamese rationale for strengthening competence in conservative musculoskeletal care throughout the health system, rather than only in specialist centers.

**2. The policy environment for integrating conservative musculoskeletal care**

Vietnam's health system provides a receptive environment for strengthening conservative musculoskeletal care. Traditional medicine is a long-established, state-supported component of Vietnamese health care. Its two forms, *thuoc nam* and *thuoc bac*, are deeply rooted in the country, and national policy has emphasized combining traditional and modern medicine and integrating traditional medicine into public services for decades.[10] Nevertheless, traditional medicine accounts for only a small proportion of clinical activity—approximately 3 percent of all medical examinations and treatments nationally in 2025 (about seven million visits)—and the Ministry of

Health has acknowledged persistent gaps in service capacity, financing, and referral arrangements. In 2025, the national leadership renewed calls for closer integration of traditional and modern medicine in training, prevention, and treatment.[11] This ambition to strengthen integration rather than establish isolated services creates a policy context into which improved conservative musculoskeletal care could fit naturally.

This direction is reinforced internationally. The World Health Organization Global Traditional Medicine Strategy 2025–2034 calls for the evidence-based integration of traditional, complementary, and integrative medicine into national health systems and identifies the absence of standardized, evaluable integration models as a barrier to progress.[12] Conservative musculoskeletal care—manual, non-pharmacological, and non-surgical—sits at the intersection of this agenda and mainstream orthopedic practice. It can be defined, taught, and evaluated in accordance with the strategy's standards for evidence and safety while remaining within the scope of conventional clinical care. Strengthening such care therefore advances two policy goals at once: improving musculoskeletal outcomes and promoting a more integrated health system. The remaining practical question concerns the conceptual and educational content that should inform this development. In this regard, the Japanese experience provides a potentially useful model.

## IV. JUDO-SEIFUKU AS AN INTEGRATED MODEL OF CONSERVATIVE MUSCULOSKELETAL CARE

Judo-Seifuku is often described externally as a Japanese occupation, but this review focuses on what it demonstrates about the delivery of conservative care rather than its professional status. In Japan, it is an organized, state-licensed field in which practitioners manage fractures, dislocations, sprains, contusions, and strains non-surgically,[13] and judo therapists are documented within the World Health Organization's global review of the legal status of traditional and complementary/alternative medicine.[14] In clinical terms, however, Judo-Seifuku can be understood as an integrated model of conservative musculoskeletal care: a continuous treatment process that unites reduction, fixation, and aftercare and is delivered as a continuous course of care, from the acute injury through to functional recovery. This integration—not any individual maneuver—constitutes the model's transferable content. Reduction itself is not the distinguishing feature, as closed reduction is performed worldwide. Rather, the model is distinguished by how its three phases are conceptualized and connected, particularly by its approach to fixation.

### 1. Fixation as an active therapeutic process

In routine practice, fixation is often treated as a passive interval: the injured area is immobilized until the tissue heals, after which rehabilitation begins. In the Judo-Seifuku model, fixation is instead regarded as a therapeutic process in its own right. Its purpose is not merely to prevent movement but to achieve four concurrent aims: protecting injured tissue, maintaining mechanical stability and alignment, enabling early functional recovery, and supporting graded functional improvement.

Fixation is therefore an active phase of treatment rather than a pause preceding rehabilitation. In this sense, it serves as a bridge between structural stabilization and progressive functional recovery.

This active conception of fixation differs from both prolonged immobilization and rehabilitation initiated only after support is removed. Rather than separating protection and recovery into consecutive phases—first immobilization and then rehabilitation—fixation is continually adjusted, as healing progresses, to balance these objectives—for example, changing the position or angle of immobilization to a safe range, reducing the extent of the fixation, graduating weight-bearing in lower-limb fractures, and permitting movement within safe limits of amount, angle, and range. Protection and functional restoration can thus proceed concurrently rather than sequentially.

Consequently, functional recovery begins during rather than after fixation. Within the limits imposed by safety and stability, controlled loading, muscle activation, range-of-motion exercises for adjacent and uninvolved joints, and edema management commence while support remains in place. These interventions are progressively advanced as healing proceeds. The support is selected and adjusted with the same aims in mind: protecting the injury while permitting as much safe function as the stage of healing allows.

The intended trajectory is for functional recovery to be substantially advanced by the time fixation is removed. This approach contrasts with prolonged rigid immobilization, which may secure union at the cost of stiffness, muscle atrophy, and disuse, all of which must then be laboriously reversed. Active fixation is specifically intended to prevent this trade-off, whereby immobilization used to promote structural healing becomes a cause of functional loss. Evidence that immobilization technique and duration materially affect outcomes is consistent with this approach.[4] The model's distinctive contribution is to make active management during fixation an explicit therapeutic objective rather than an afterthought.

**2. Reduction, fixation, and aftercare within a single continuum**

Fixation conceptualized in this way is meaningful only as part of a continuum. Reduction is performed not as an isolated technical intervention but as the first stage of a plan in which fixation and rehabilitation have already been anticipated. The quality of reduction is assessed according to the stability and function it enables, rather than by imaging alone. Aftercare, correspondingly, is not a separate rehabilitative episode transferred to another service after healing is complete, but a continuation of the process that began at the time of injury.

Delivering these phases as a continuous course within a single clinical plan allows structural healing and functional recovery to progress in tandem—the combined endpoint previously identified as characteristic of mature conservative care. The transferable lesson for other health systems is therefore conceptual and organizational rather than occupational. It concerns how conservative treatment is conceived, sequenced, and taught and could, in principle, be adopted wherever musculoskeletal

injuries are managed.

The scope of this argument should be stated clearly. Many orthopedic and rehabilitation clinicians already apply similar principles in high-quality conservative practice, and none of the individual components is unique to Japan. The value of the Judo-Seifuku framework lies not in originating these techniques but in explicitly organizing reduction, fixation, and aftercare into a coherent educational and clinical model. It thereby transforms an approach that is often tacit and dependent on specialist expertise into one that can be defined, taught, assessed, and delivered consistently across a wider workforce. The model is therefore proposed here as an organizational and educational framework, rather than as a novel set of maneuvers.

## V. BUILDING CONSERVATIVE MUSCULOSKELETAL COMPETENCE IN VIETNAM'S WORKFORCE

If the contribution of Judo-Seifuku is conceptual and educational, it should be realized in Vietnam by training the clinicians already employed within the health system rather than creating a new occupation. The integrated approach to conservative care—reduction, active fixation, monitoring, and functional recovery delivered as a single process—can be expressed as a set of core competencies and incorporated into existing curricula and continuing professional development. The target learner groups are diverse: general practitioners and family physicians who provide first-contact care; rehabilitation physicians who manage functional recovery; orthopedic clinicians who select and supervise conservative treatment; traditional medicine physicians who already provide manual, non-pharmacological care; and rural physicians who may be the only accessible providers of musculoskeletal injury care. The aim for each group is not to convert clinicians into practitioners of a foreign discipline, but to strengthen their shared competence in conservative management within their existing roles. Because musculoskeletal injuries are commonly encountered in primary care and community settings, competence in conservative musculoskeletal management should not be restricted to orthopedic specialists.

Framed as a set of competencies rather than an occupation, the content becomes transferable. Experience in capacity building in other areas of musculoskeletal and surgical care suggests that sustained education and local ownership produce more enduring improvements than one-off service delivery and that developing local workforce capability prevents dependency.[15] This experience also indicates the value of practical educational methods—including structured curricula, competency assessment, and accessible teaching materials such as procedural videos—that enable consistent training at scale.[16] Applied to conservative musculoskeletal care, these methods would allow concepts drawn from the Judo-Seifuku model to be taught, assessed, and standardized within Vietnamese institutions while being adapted to local injury patterns, resources, professional roles, regulations, and health-system needs.

**Proposed educational competencies**

To translate these concepts into practice, they can be expressed as a defined set of teachable and assessable competencies in conservative musculoskeletal care. A minimum core would include the principles of reduction, including how alignment is restored and assessed; the principles of active fixation, including how injured tissue is protected and stability is maintained while safe, graded function is enabled; patient assessment and case selection, including recognition of injuries that are and are not suitable for conservative treatment; monitoring to detect complications and loss of position in time for intervention; functional recovery during fixation, including the initiation and progression of movement, muscle activity, and loading within safe limits; and referral criteria, including when and how to escalate to surgical care. Defined in this way, the competencies can be embedded in curricula, taught across clinical disciplines, and assessed against explicit standards. This is the practical form in which the model contributes to medical education. These competencies are particularly relevant at primary care and district hospital levels, where musculoskeletal injuries are frequently encountered. However, specialist support may not be immediately available.

Two safeguards are essential for responsible implementation. Clinicians' competence must be assessed against defined standards before they practice independently, rather than inferred from their exposure to training. Clear referral pathways must also connect conservative and surgical services so that patients with injuries beyond the scope of conservative care are escalated promptly. With these safeguards in place, strengthening competence in conservative care across the existing workforce could provide a low-infrastructure, system-wide improvement without requiring the importation of a profession.

A further consideration concerns settings beyond routine care. In Japan, Judo-Seifuku practitioners have contributed to organized disaster relief efforts, providing care for acute injuries, musculoskeletal complaints, and symptoms associated with disuse.[17,18] Whether a similarly organized contribution could eventually complement disaster response in Vietnam lies beyond the scope of this review. It is noted only to illustrate that strengthening competence in conservative musculoskeletal care may yield benefits beyond everyday practice. The primary case, however, rests on its application to routine care.

## VI. LIMITATIONS

Several limitations should be acknowledged. As a narrative review, this article did not follow a systematic search or appraisal protocol. The literature considered is therefore subject to selection bias, and the synthesis reflects the authors' interpretation rather than a formal grading of the evidence. The integrated model described was drawn largely from Japanese practice, and rigorous comparative evidence supporting the specific claim that an explicitly organized reduction–fixation–aftercare approach improves outcomes relative to usual conservative care remains limited, particularly outside Japan. Most importantly, the review presents no Vietnam-specific outcome data. Its

arguments for strengthening conservative musculoskeletal care in Vietnam and for the educational value of the concepts discussed are therefore conceptual and contextual. Their clinical benefits can be established only through prospective evaluation conducted in Vietnam. These limitations define an agenda for subsequent research rather than negating the rationale for such work.

## VII. CONCLUSION

To address its substantial burden of musculoskeletal injury, Vietnam needs not the importation of a foreign profession but the strengthening of competence in conservative musculoskeletal care among its existing clinicians in orthopedics, rehabilitation, primary care, family medicine, and traditional medicine. Conservative management is an evidence-based treatment strategy that aims to achieve both structural healing and functional recovery across a broad range of musculoskeletal injuries. Its success depends on reduction, fixation, monitoring, and functional recovery being delivered as an integrated process. The enduring value of Judo-Seifuku lies not in the occupation itself but in its articulation of this integrated, continuous system and, above all, its conception of fixation as an active therapeutic phase during which functional recovery is already underway. Treated as a source of clinical concepts and educational content, adapted to the local context, and subjected to prospective evaluation, this model could help Vietnam strengthen conservative musculoskeletal care within its own health system and on its own terms.

## CONFLICT OF INTEREST STATEMENT

The author is involved in international educational and professional activities related to Judo-Seifuku through the Japan Judo Therapist Association. No funding was received for the present study, and no external organisation had any role in the design, conduct, analysis, interpretation, or preparation of this manuscript. The institutional conflict-of-interest review has been completed, and approval number 2026-0162 (September 3, 2026) has been confirmed as final.

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## ETHICS STATEMENT

This narrative review synthesises previously published literature and does not report primary data involving human subjects. The study was submitted to the research ethics committee of Teikyo Heisei University (Institutional Review Board for Human Research), which determined that formal institutional review board (IRB) approval was not required for this type of study. As the study is exempt, no IRB determination number is issued. The work complies with the Declaration of Helsinki where applicable.

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