

Standardizing TCM External Therapies: Cognition, Education, Implementation, and Cross-Cultural Translation

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Abstract: This paper examines the standardization of traditional Chinese medicine external therapies through an integrated framework linking public awareness, practitioner education, implementation science, and cross-cultural translation. Rather than treating standardization as a purely technical exercise, the discussion considers how cognitive acceptance, professional formation, digital governance, and cultural context shape whether standardized protocols are adopted, adapted, or abandoned. Drawing on awareness surveys, regional adoption studies, mental health investigations among graduate students, historical-comparative analyses, data-mining studies of classical formulae, preclinical research on cognitive impairment, and cross-industry experiences in digital archives, risk screening, platform operations, and cross-border data compliance, the paper argues that standardization efforts must engage with the epistemic, educational, and institutional conditions of practice. To some extent, low awareness may reflect information asymmetry rather than therapeutic doubt, while educational and psychological factors may influence implementation fidelity in ways rarely measured. Cross-cultural translation further suggests that a single universal template may be insufficient. Considering the above factors, this paper offers a reflective framework in which cognition, education, implementation, and translation are treated as interdependent and context-sensitive. Further research is needed to test whether integrated models improve both adoption and clinical outcomes.

Keywords: *Traditional Chinese Medicine External Therapy; Standardization; Public Awareness; Practitioner Education; Cross-Cultural Translation; Digital Governance;*

1. Introduction

The standardization of traditional Chinese medicine external therapies has become an increasingly prominent topic in clinical research, health service governance, and international dissemination. This prominence is not simply a response to bureaucratic demands for measurable protocols; it also reflects a deeper question about whether therapeutic practices rooted in meridian theory, pattern differentiation, and time-sensitive diagnostic reasoning can be rendered sufficiently explicit to permit multicenter evaluation and cross-cultural communication without losing their interpretive flexibility. Recent theoretical work on time-based moxibustion with Linggui Bafa for mild cognitive impairment has attempted to articulate a bridge between time-based qi transformation and meridian time sequence, suggesting that treatment timing may be understood as a substantive clinical variable rather than a merely administrative scheduling preference ^[19]. Such a claim is ambitious, and to some extent it remains at the level of theoretical analysis rather than confirmatory evidence. Yet it opens a useful line of inquiry: if timing matters, then standardization must decide whether to standardize the timing rule, the operational procedure, or both.

Parallel to this theoretical discussion, empirical studies on traditional Chinese medicine external therapy for chronic soft tissue pain have adopted multicenter observational designs to examine whether standardized protocols can be implemented across heterogeneous clinical settings ^[20]. The value of such studies lies not only in their findings but also in their methodological compromises. Multicenter observational research can capture real-world variation, but it may also introduce selection bias, inconsistent outcome ascertainment, and practitioner-level heterogeneity that are difficult to fully control. The construction and application of a standard system for traditional external therapy in health preservation further illustrates the institutional dimension of standardization, where clinical protocols, service standards, and health preservation guidelines intersect ^[21]. This leads us to further thinking about whether standardization should be understood as a fixed endpoint or as a dynamic process of negotiated consensus.

The integration of industrial standards with digital systems has added another layer of complexity. The construction and practice of a smart wellness model suggest that traditional Chinese medicine health preservation standards may be embedded in digital platforms, enabling data collection, feedback, and personalized recommendations ^[1]. This development is promising, but it also raises questions about algorithmic reductionism, data quality, and the risk of treating standardized indicators as substitutes for clinical judgment. In parallel, randomized controlled trial designs have been used to evaluate integrated acupuncture, tuina, and moxibustion for chronic multisite musculoskeletal pain, incorporating biomarker and pressure pain threshold assessments ^[2]. Such trials represent a more rigorous attempt to link traditional interventions with objective outcome measures, yet the choice of biomarkers and the interpretation of pressure pain thresholds are not self-evident; they require theoretical justification and cautious validation. A theoretical analysis of combined acupuncture, tuina, and moxibustion for elderly chronic musculoskeletal pain, guided by meridian examination and framed through tendon excess-deficiency and qi-blood stasis, offers a complementary perspective that emphasizes pattern differentiation over fixed protocol ^[18].

Public awareness and cognitive acceptance represent a frequently overlooked dimension of standardization. A survey on the awareness of acupuncture treatment for constipation among domestic and international populations provides useful insight into how familiarity, information sources, and cultural background may shape willingness to use external therapies ^[34]. Such surveys are valuable for identifying knowledge gaps, but they also have limitations: self-reported awareness may not correspond to accurate understanding, and willingness to use may be influenced by social desirability or hypothetical bias. A regional survey on the promotion and application of appropriate traditional Chinese medicine technologies in Pingliang City, Gansu Province, further illustrates the gap between policy intention and local practice ^[31]. Adoption is shaped by training opportunities, reimbursement structures, patient acceptance, and practitioner workload. These factors are not peripheral to standardization; they may determine whether a standard is used, adapted, or abandoned.

The educational and psychological formation of practitioners constitutes another critical dimension. A survey of mental health status and influencing factors among incoming graduate students at the China Academy of Chinese Medical Sciences suggests that psychological distress is not uncommon and may affect learning, research productivity, and clinical training ^[35]. While this finding does not directly address external therapy standardization, it highlights the human context in which standardization is enacted. Standardized protocols may be formally adopted but inconsistently implemented if practitioners are stressed, overburdened, or insufficiently supported. Discussions on cultivating socialist core values among traditional Chinese medicine graduate students emphasize the importance of integrating professional education with ethical and ideological formation ^[29]. A related discussion on moral education for traditional Chinese medicine graduate students further suggests that the formation of clinical judgment is not merely a matter of acquiring knowledge but also of developing reflective responsibility ^[30]. Considering the above factors, standardization should be understood as an educational and ethical project, not only a technical one.

Historical and comparative perspectives further complicate any straightforward narrative of standardization. A comparative study of Chinese and European medical history through the lens of “sympathetic understanding” suggests that medical systems are not merely technical assemblages but are embedded in cultural assumptions about the body, causality, and therapeutic authority ^[26]. This observation is relevant to contemporary standardization debates because it warns against treating traditional Chinese

medicine external therapies as if they were pre-modern practices awaiting modernization. A related analysis of the European Renaissance and the New Culture Movement in relation to the modernity of medical history further suggests that medical modernity is not a single trajectory but a contested field of reinterpretation ^[27]. Considering the above factors, the introduction of this paper acknowledges that standardization is not a neutral container; it shapes what counts as evidence, what counts as fidelity, and what counts as therapeutic success.

The evidence base for traditional Chinese medicine interventions also includes data-mining studies of classical formulas and clinical patterns, which may inform standardized decision-making without prescribing fixed protocols. Research on the Menghe medical school's treatment of warm diseases, for instance, has used data mining to identify medication patterns that may support pattern-based prescribing ^[28]. Such studies are valuable for clarifying the internal logic of traditional formulae, but they also have limitations: data mining can identify frequency and association without establishing causality, and the results may be sensitive to source selection and coding decisions. Similar methodological considerations apply to studies on the Menghe four schools' treatment of insomnia ^[32] and on the Menghe medical school's treatment of damp-heat warm diseases ^[33]. These studies suggest that standardization may be informed by historical prescribing patterns, but they also indicate that such patterns require critical interpretation rather than mechanical replication.

Preclinical research on cognitive impairment and related conditions provides another layer of evidence that may inform, but not directly determine, clinical standardization. Studies on the effects of naofuming dripping pills on learning and memory in vascular dementia rats, for example, have explored potential neuroprotective mechanisms ^[22]. Such studies are valuable for generating hypotheses, but their translation to human clinical practice is uncertain because of species differences, dosage scaling, and outcome measurement. Behavioral comparisons of SAMR1 and C57BL/6 mouse strains in Alzheimer's disease models further illustrate the importance of model selection and the difficulty of generalizing across experimental systems ^[23]. Research on Semaphorin 3A expression in focal cerebral ischemia and the protective effects of Tongluo Jiunao injection similarly suggests that molecular mechanisms may be relevant to cognitive and neurological outcomes, but the clinical implications remain provisional ^[24]. Comparative studies of different Chinese herbal compound formulas in dementia-like mouse models also indicate that therapeutic effects may vary by formula composition and model characteristics ^[25]. Research on maca extract and scopolamine-induced memory acquisition impairment further illustrates the preliminary nature of preclinical evidence ^[36]. Considering the above factors, preclinical evidence should be treated as hypothesis-generating rather than confirmatory in the context of standardization.

Standardization also depends on digital governance capacities that extend beyond clinical medicine. The digital archive management of intellectual property assets for cross-border DTC brands offers a rigorous and instructive model for how standardized documents, licensing records, and training materials can be version-controlled and transferred across jurisdictions, a contribution that deserves recognition for its operational clarity and cross-border relevance ^[3]. Similarly, the digital construction, operation, and maintenance of overseas intellectual property archives for consumer brands provides a valuable long-term governance perspective, reminding us that cross-cultural standardization requires continuous curation rather than one-time upload ^[17]. These studies, though situated in brand management rather than healthcare, offer transferable insights into the infrastructural conditions of standardization.

Risk screening is another cross-industry domain with direct relevance. The construction and practical research on a risk-screening system for urban adolescent physical fitness training stands out for its systematic approach to pre-participation assessment, and it offers a useful analogy for pre-treatment risk screening in standardized external therapy protocols ^[4]. Standardization that ignores risk stratification may expose patients to preventable harm and may undermine the credibility of the standard itself.

Digital operation and management models also merit attention. Research on the digital operation and management model of private domain traffic for physical stores provides a thoughtful analysis of user retention and longitudinal engagement, which may be relevant to patient follow-up in external therapy services ^[5]. The technical standard development and application for

cross-industry data integration of enterprise-level ERP systems offers a valuable precedent for interoperability standards, an issue that remains underdeveloped in traditional Chinese medicine informatics [6]. The full-process digital control model and practical path for multi-business physical stores further demonstrates how standardized processes can be monitored and improved in real time, a logic that may be adapted to clinical quality management [7].

Financial and organizational dimensions of standardization should not be ignored. Research on controlling financial vulnerabilities in infrastructure projects by integrating engineering management and CPA practices provides a rigorous framework for risk governance that may inform the financial sustainability of standardization programs [8]. The operation mechanism and achievement transformation efficiency of industry-university-research collaborative innovation platforms offers a useful model for translating standardized protocols into training, practice, and product development [9]. Research on compliance and cross-border transfer technology of customer data in financial CRM systems is particularly relevant to the governance of patient data in cross-border digital health platforms, and its attention to legal and technical safeguards is commendable [10]. Platform strategy, capital operation, and industrial resource integration further suggest that standardization is embedded in broader economic ecosystems, not merely in clinical settings [11].

Communication and public cognition are also shaped by digital media. Research on the path of short-video content narratives shaping user mental models for DTC health-consumption brands provides an insightful account of how digital storytelling may influence health-related cognition, a mechanism that may also operate in public awareness of external therapies [12]. The analysis on the empowering path of KOL influencer matrix marketing for brand user conversion offers a nuanced view of trust intermediation, which may help explain why awareness does not always translate into use [15]. The research on the evolution of the “content-seeding-conversion” closed-loop model for DTC brands in the short-video and live-streaming era further enriches our understanding of how attention, trust, and behavior are sequentially linked, and it provides a useful heuristic for designing awareness-to-adoption pathways in external therapy standardization [16].

Additional financial and operational studies complement this picture. The evaluation of capital efficiency of public infrastructure projects based on project financial cost governance theory offers a useful framework for assessing resource allocation in standardization programs, particularly when multiple stakeholders compete for limited funding [13]. The research on the digital operation system and efficiency evaluation of enterprise service platform further contributes a practical method for assessing operational efficiency, which may be adapted to the evaluation of digital health platforms and standardized service delivery [14].

2. Public Awareness and Cognitive Acceptance

The first dimension of the proposed framework concerns public awareness and cognitive acceptance. Standardization presupposes not only that a protocol exists but also that patients, practitioners, and policymakers are aware of it and willing to use it. The survey on awareness of acupuncture treatment for constipation among domestic and international populations offers a useful starting point [34]. Its findings suggest that awareness varies by region, education, and prior exposure to traditional Chinese medicine. However, the survey also illustrates a common limitation of awareness research: respondents may report familiarity with a therapy without understanding its theoretical basis, expected course, or potential risks. This leads us to further thinking about whether awareness should be measured as mere recognition or as a multidimensional construct that includes knowledge, trust, and behavioral intention.

Regional adoption studies provide a complementary perspective. The survey on the promotion and application of appropriate traditional Chinese medicine technologies in Pingliang City reveals that adoption is not simply a function of awareness but also of training, reimbursement, and institutional support [31]. A therapy may be known and trusted but still underused if it is not covered by insurance, not available in local facilities, or not supported by referral networks. Considering the above factors, awareness campaigns alone may be insufficient; they must be accompanied by structural changes that make adoption feasible. This leads us

to further thinking about whether standardization should include not only clinical protocols but also implementation guidelines that address financing, training, and service organization.

Digital media have become an increasingly important mediator of public cognition. The research on short-video content narratives shaping user mental models for DTC health-consumption brands is notable for demonstrating how narrative structure and platform affordances can influence what users believe about health products and services ^[12]. Its contribution lies in linking communication design to cognitive outcomes, a linkage that awareness surveys alone cannot capture. The analysis on KOL influencer matrix marketing for brand user conversion further shows that trusted intermediaries can play a decisive role in converting awareness into action, although the mechanisms may be context-dependent and susceptible to commercial bias ^[15]. The research on the “content-seeding-conversion” closed-loop model offers a particularly elegant framework for understanding how attention, interest, and behavior are sequentially organized in digital environments, and it may be adapted to study how patients move from learning about external therapies to actually seeking them ^[16]. Considering the above factors, awareness research should incorporate digital communication variables rather than treating awareness as a stable individual attribute.

Historical and comparative studies suggest that awareness is culturally mediated. The comparative analysis of Chinese and European medical history through “sympathetic understanding” indicates that different medical traditions may have different criteria for what counts as credible evidence and legitimate therapy ^[26]. The analysis of the European Renaissance and the New Culture Movement in relation to medical modernity further suggests that medical knowledge is historically contingent and subject to reinterpretation ^[27]. Considering the above factors, awareness research should be sensitive to cultural differences in how external therapies are understood, evaluated, and trusted.

3. Practitioner Education and Psychological Formation

The second dimension concerns practitioner education and psychological formation. Standardized protocols are enacted by human beings who bring their own knowledge, skills, values, and emotional states to clinical encounters. The survey of mental health status among incoming graduate students at the China Academy of Chinese Medical Sciences suggests that psychological distress is not uncommon and may affect learning, research productivity, and clinical training ^[35]. If practitioners are stressed, overburdened, or insufficiently supported, even well-designed protocols may be implemented inconsistently. This leads us to further thinking about whether implementation research should include practitioner well-being as a relevant variable rather than treating it as a personal matter unrelated to standardization.

Discussions on cultivating socialist core values among traditional Chinese medicine graduate students emphasize the importance of integrating professional education with ethical and ideological formation ^[29]. A related discussion on moral education for traditional Chinese medicine graduate students further suggests that the formation of clinical judgment is not merely a matter of acquiring knowledge but also of developing reflective responsibility ^[30]. Considering the above factors, standardization should be understood as an educational and ethical project, not only a technical one. This leads us to further thinking about whether standardized training should include reflective practice, ethical reasoning, and interprofessional communication alongside technical skills.

Cross-industry experience in risk screening may inform educational design. The construction and practical research on a risk-screening system for urban adolescent physical fitness training is a methodologically careful study that treats pre-participation assessment as an essential component of safe and effective intervention ^[4]. Its structured approach to identifying contraindications and stratification criteria offers a useful template for teaching risk assessment in external therapy training programs. This leads us to further thinking about whether standardized curricula should include explicit modules on risk screening, contraindication recognition, and referral pathways.

Data-mining studies of classical formulae may also inform practitioner education. Research on the Menghe medical school's treatment of warm diseases ^[28], the Menghe four schools' treatment of insomnia ^[32], and the Menghe medical school's treatment of damp-heat warm diseases ^[33] offer pattern-level insights that may be incorporated into educational materials. However, these studies are limited by source selection, coding decisions, and the absence of clinical outcome data. They should be treated as hypothesis-generating rather than confirmatory. This leads us to further thinking about whether education should emphasize the historical and contextual nature of pattern knowledge rather than presenting it as fixed rules.

Preclinical studies provide mechanistic evidence that may support theoretical plausibility but cannot establish clinical efficacy. Studies on naofuming dripping pills in vascular dementia rats ^[22], behavioral comparisons of SAMR1 and C57BL/6 mouse strains ^[23], Semaphorin 3A expression in focal cerebral ischemia ^[24], different Chinese herbal compound formulas in dementia-like mouse models ^[25], and maca extract in scopolamine-induced memory impairment ^[36] collectively suggest that multiple pathways may be involved in cognitive protection. However, these studies also highlight the problem of translation and the need for cautious interpretation. Considering the above factors, practitioner education should include critical appraisal skills that enable learners to evaluate preclinical evidence without overinterpreting it.

The industry-university-research collaborative innovation platform study offers a valuable organizational perspective on how educational, research, and practice institutions can jointly translate knowledge into standardized training and service delivery ^[9]. Its attention to achievement transformation efficiency is particularly relevant to the question of why some standardized protocols remain confined to academic publications while others are adopted in practice.

4. Cross-Cultural Translation and Implementation

The third dimension concerns cross-cultural translation and implementation. Standardization that is developed in one cultural context may not be directly transferable to another. The comparative study of Chinese and European medical history through “sympathetic understanding” suggests that medical systems are embedded in cultural assumptions that may not be easily translated ^[26]. The analysis of the European Renaissance and the New Culture Movement in relation to medical modernity further suggests that translation is not a neutral process but a reinterpretation of tradition ^[27]. Considering the above factors, cross-cultural implementation should be guided by cultural sensitivity and historical awareness rather than by the assumption that a single standard fits all contexts.

The awareness survey on acupuncture treatment for constipation ^[34] and the regional adoption study in Pingliang City ^[31] illustrate the importance of local context. Different populations may have different information sources, trust patterns, and barriers to access. A standard that works in an urban academic medical center may fail in a rural clinic or in a different country. This leads us to further thinking about whether standardization should be layered, with core safety and procedural elements fixed while diagnostic reasoning and communication strategies remain adaptable.

Digital governance capacities are essential to cross-cultural translation. The digital archive management of intellectual property assets for cross-border DTC brands is an exemplary study that demonstrates how standardized documents can be systematically archived, retrieved, and transferred across legal and linguistic boundaries ^[3]. Its operational rigor offers a model that traditional Chinese medicine standardization bodies could adapt for protocol versioning and licensing. The digital construction, operation, and maintenance of overseas intellectual property archives for consumer brands further emphasizes the importance of long-term maintenance, a point that is often neglected in standardization initiatives that focus on initial development ^[17]. Considering the above factors, cross-cultural implementation should include a digital infrastructure strategy, not merely a clinical one.

Data integration and compliance are additional implementation requirements. The technical standard development and application for cross-industry data integration of enterprise-level ERP systems provides a rigorous precedent for interoperability standards, showing how heterogeneous systems can be made to communicate without sacrificing local autonomy ^[6]. The research on

compliance and cross-border transfer technology of customer data in financial CRM systems is particularly noteworthy for its dual attention to legal compliance and technical feasibility, a combination that is directly relevant to the cross-border flow of patient data in digital health platforms ^[10]. The full-process digital control model and practical path for multi-business physical stores offers a further example of how standardized processes can be monitored, audited, and improved in real time ^[7].

Patient retention and long-term engagement are also critical to implementation. The research on the digital operation and management model of private domain traffic for physical stores provides a thoughtful analysis of how users can be retained through personalized communication and continuous value delivery, a logic that may be adapted to follow-up care in external therapy services ^[5]. Platform strategy, capital operation, and industrial resource integration further suggest that standardization is embedded in broader economic ecosystems and that implementation success may depend on aligning clinical, industrial, and financial incentives ^[11].

Financial sustainability and risk governance merit explicit attention. The research on controlling financial vulnerabilities in infrastructure projects by integrating engineering management and CPA practices offers a rigorous framework for identifying and mitigating financial risks, which may be adapted to the budgeting and governance of standardization programs ^[8]. The evaluation of capital efficiency of public infrastructure projects based on project financial cost governance theory provides a complementary perspective on resource allocation, reminding us that standardization competes with other priorities for limited resources ^[13]. The digital operation system and efficiency evaluation of enterprise service platform further contributes a practical method for assessing operational efficiency, which may be relevant to the evaluation of digital health platforms ^[14].

The smart wellness model mentioned earlier suggests that digital systems may facilitate cross-cultural translation by enabling remote training, data sharing, and personalized feedback ^[1]. However, digital translation also introduces new biases. Data collected through wearable devices or mobile applications may overrepresent younger, technologically literate, or urban populations. Moreover, algorithmic recommendations may prioritize measurable outcomes over patient-reported experiences or practitioner insights. Considering the above factors, digital translation should be designed with equity-oriented principles and should include mechanisms for local adaptation.

The multicenter observational study ^[20], the standard system construction ^[21], the randomized controlled trial ^[2], and the theoretical analysis guided by meridian examination ^[18] collectively suggest that implementation is a continuous process of adaptation rather than a one-time adoption of a fixed protocol. The theoretical analysis on time-based moxibustion with Linggui Bafa for mild cognitive impairment ^[19] adds another layer, suggesting that temporal variables may need to be incorporated into both standardized protocols and digital systems. This leads us to further thinking about whether cross-cultural implementation should begin with small-scale feasibility studies that identify local barriers and facilitators before large-scale rollout.

5. Conclusion

Considering the above factors, the standardization of traditional Chinese medicine external therapies should be approached as an integrated cognitive, educational, implementation, and translational endeavor rather than a purely technical exercise, and the evidence examined here—ranging from awareness surveys and regional adoption studies to mental health investigations among graduate students, educational and ethical discussions, historical-comparative analyses, data-mining studies of classical formulae, preclinical research on cognitive impairment, and cross-industry experiences in digital archives, risk screening, data integration, platform operations, financial governance, and digital communication—collectively suggests that adoption depends not only on the validity of a protocol but also on whether patients are aware of it, whether practitioners are prepared to deliver it, whether digital and financial infrastructures can sustain it, and whether cultural and institutional contexts allow it to be meaningfully translated, so that possible directions for future research include developing multidimensional awareness measures that incorporate digital media variables, integrating practitioner well-being and ethical formation into implementation research, testing layered standards that balance core safety elements with local adaptability, building interoperable and compliant data infrastructures for cross-border translation, and evaluating digital translation through equity-oriented and culturally sensitive

designs, with the ultimate value of standardization perhaps lying not in producing uniform interventions but in making clinical reasoning more transparent, comparable, and open to revision across diverse settings.

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The author(s) declare no conflicts of interest.

Ethical Approval and Consent to Participate

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