Journal of Population Therapeutics & Clinical Pharmacology

RESEARCH ARTICLE
DOI: 10.53555/kqg22g98

Physician in Charaka Samhita: Competence, Conduct, and Therapeutic Accountability

Devanand Upadhyay*[1], Brij Kumar Dwibedy[2]

*Department of Siddhant Darshan, Faculty of Ayurveda, IMS, BHU

***Corresponding author:** Devanand Upadhyay,
dev.asdbhu10@bhu.ac.in. https://orcid.org/0000-0003-3623-0388

ABSTRACT

Charaka Samhita presents the physician (bhishak/vaidya) as the decisive determinant of therapeutic success, not by social designation but by cultivated competence, disciplined conduct, and validated clinical outcomes. This review synthesizes physician related statements across Sutra, Vimana, Nidana, Sharira, and Indriya Sthana and mapping each concept to exact verse clusters. Charaka samhita describes the physician as a person who becomes pranada through ongoing self development and disciplined effort, not by title alone, disease removal as the operational marker of excellence and siddhi as the public proof of correct application. Clinical legitimacy is restricted to physicians who possess reliable memory (smriti), sound causal and clinical reasoning (hetuyuktigyana), self control in conduct (jitatma), and attentive presence in action (pratipattiman). Within the chatushpada, the physician is designated pradhana karana, integrating drug, attendant, and patient through informed selection, sequencing, and monitoring. It further establishes anti quackery safeguards, epistemic screening through debate discipline, structured decision boundaries for refusal based on treatability and context, and a prognostic ethic in Indriya Sthana that governs acceptance, restraint, and communication. Overall, Charaka Samhita frames physician identity as accountable, reasoning centered, and ethically regulated, with explicit safeguards against chance based practice.

Keywords: Charaka Samhita; physician; bhishak; vaidya; chatushpada; pradhana karana; yukti; siddhi; pranabhisara; Indriya Sthana; pledge; anti quackery.

1. Introduction

Medical traditions are often studied through their descriptions of disease, medicines, and treatment methods. The Charaka Samhita, however, places the physician at the center of medical practice. It repeatedly emphasizes that medicines and procedures do not act independently; their success depends on the physician who understands, applies, and regulates them. Charaka Samhita describes the aspiring physician as one who must engage in sustained effort to acquire physician qualities, and identifies such disciplined development as the basis of becoming true giver of life (pranada)(Cha.Su. 1/133). Therapeutic success (siddhi) is presented as the visible proof of correct application (samyak prayoga) and, by extension, of physician competence (Cha. Su. 1/134–135). [1]

The physician (bhishak) is explicitly designated as the pradhana karana (primary cause) of treatment, while the patient, medicines, and attendants function as supportive limbs (chatushpada) dependent on the physician's guidance (Cha.Su. 9/12–13; Cha. Su. 25/40). [2,3] Success in treatment is therefore not attributed to drugs alone but to the physician's ability to integrate all components of therapy.

The text clearly limits the right to practice medicine. Only those endowed with memory (smriti), rational understanding of causation (hetu yukti gyana), self restraint (jitatma), and presence of mind (pratipattiman) are considered fit to treat patients (Cha. Su. 2/36).[4] Practice undertaken without knowledge is described as dangerous, and any success achieved by ignorant physicians is said to occur merely by chance (yadrichchhaya) (Su. 9/16–17).[2]

Charaka further insists that treatment must begin only after proper examination of the disease, including its nature, location, and specific causative factors (Su. 18/46–47)[5] followed by appropriate selection of medicines and consideration of place, time, and measurement (Su. 20/20–22).[6] Ethical responsibility is equally emphasized: the physician is advised to show compassion toward patients while exercising restraint in incurable conditions (Cha. Su. 9/26; Cha. Ni. 2/27).[2] The text also strongly warns against pseudo physicians and outlines clear behavioral markers to identify and avoid them (Su. 11/50–53; Su. 29/8–9). [7,8]

Taken together, these teachings present a coherent model of medical practice in which competence, rational judgment, ethical discipline, and accountability are inseparable. This review synthesizes physician centric teachings across the Charaka Samhita into several domains, demonstrating that Charaka advances a structured and enduring theory of medical professionalism rather than isolated clinical or ethical instructions.

2. Materials and Methods

Verses with terms Bhishak, Bhishaga, Vaidya, Chikitisaka, Chikitsa concerning the role of the physician were compiled from the Charaka Samhita, focusing on competence, professional conduct, clinical reasoning, prognostic judgment, therapeutic decision-making, and safeguards against unqualified practice. The review examined Sutra, Vimana, Nidana, Sharira, and Indriya Sthana, which contain explicit discussions on physician responsibilities, ethical discipline, and clinical governance. Citations are presented as Cha. [Sthana] [Chapter]/[Verse]. An analytical thematic approach combining deductive and inductive reasoning was used. Related passages were inductively grouped by functional meaning and mapped to verse clusters to ensure transparency and conceptual coherence.

3. Physicians Across Diverse Perspectives

3.1 Physician and its building competence

Charaka defines the aspiring physician as one committed to sustained effort toward acquisition of physician qualities. Perseverance is not presented as optional motivation but as a defining requirement of medical formation; pranada status is explicitly contingent upon disciplined self development (Cha. Su. 1/133). Excellence is then made operational stating that the best physician is the one who relieves patients from disease, where disease removal functions as the sole stated criterion of excellence (Cha. Su. 1/134). The validation mechanism is siddhi when correct application produces successful outcomes, and those outcomes reflect the physician's possession of requisite qualities (Cha. Su. 1/135). Together, these verses align physician identity with outcome accountable competence rather than nominal role. [1]

3.2 Eligibility for practice: cognitive behavioral qualifications as entry conditions

Charaka Samhita sets explicit thresholds for legitimate medical practice. Only the physician endowed with memory (smriti), knowledge of causation and reasoning (hetu yukti gyana), self restraint (jitatma), and presence of mind (pratipattiman) is entitled to perform chikitsa through therapeutic combinations (Cha. Su. 2/36). Practice is framed as conditional upon defined cognitive stability and disciplined conduct, implying that therapeutic action without these attributes lacks legitimacy. [4]

3.3 Chatushpada and causal hierarchy: physician as pradhana karana

Within the four limbs of treatment, it is stated that patient, drug, and attendant function as causal supports, while the physician is the primary cause (pradhana karana) in chikitsa (Cha. Su. 9/12). The dependency is not merely asserted but clarified through analogies as potmaking materials cannot produce a pot without the potter, the remaining limbs cannot achieve therapeutic effect in the absence

of the physician (Cha. Su. 9/13). This causal hierarchy is reiterated when Charaka describes the physician as the foremost factor among the components of treatment (chikitsa anganam), stating that therapeutic efficacy becomes decisive only through the physician and the integration of its qualities (Cha. Su. 25/40). In this structure, the physician's role is integrative i.e. correct selection, sequencing, and application make the other limbs functional as therapeutic instruments. [2,3]

3.4 Risk of ignorance: chance based success and structured warnings

Charaka samhita portrays the ignorant physician as intrinsically unsafe in therapeutic action. The analogies of a blind person moving in fear and a pilotless boat driven by wind illustrate lack of direction and control in treatment (Cha. Su. 9/16). The text then states that an ignorant person who assumes physicianhood may, by chance (yadrichchhaya), save a patient with fixed lifespan yet harm many with uncertain lifespan (Cha. Su. 9/17). In contrast, Charaka Samhita defines the life promoting physician (pranabhisara) through four qualifications, that are engagement in authoritative knowledge (shastra pravritti), clear understanding (artha vigyana), correct application, and practical experience (karma darshana) (Cha. Su. 9/18). Physician identity is thus tied to demonstrable competence rather than assumed appearance. [2] This contrast is further clarified in the context of therapy application like in emesis or purgation is administered by a physician who is learned, skilled, and prompt in action, the patient attains recovery and well-being. In contrast, treatment delivered by an ignorant or pretentious practitioner may result in suffering due to excessive or inadequate administration (atiyoga, ayoga) (Cha. Su. 16/3–4).[19]

3.5 Advanced competence: the royal physician ideal and systematic disease knowledge

The royal physician (rajarha bhishak) are the ones possessing fourfold disease knowledge of causation (hetu), clinical features (linga), therapeutics (prashamana), and prevention of recurrence (apunarbhaava) (Cha. Su. 9/19). [2] Additional royal level competence is indicated through knowledge of auspicious/inauspicious determinants (shubha ashubha ashta bhava) (Cha. Sha. 4/44). [9] An upper tier of physicianhood grounded in comprehensive, systematic clinical cognition was preferred for royal physician.

3.6 Intellect refinement, competence bundles, and error prevention

The effects of instruments, scriptures, and therapeutic agents depend upon the competence of their user, thus requiring refinement of intellect (pragya shodhana) prior to treatment (Cha. Su. 9/20). The physician is expected to possess six essential qualities that are knowledge (vidya), analytical reasoning (vitarka), applied understanding (vigyana), memory retention (smriti), attentiveness and dedication (tatparata), and effective execution (kriya) as their integration enables successful attainment of therapeutic objectives. (Cha. Su. 9/21). The text further indicates that possession of even one attribute—knowledge (vidya), sound judgment (mati), practical insight (karma-drishti), repeated practice (abhyasa), therapeutic success (siddhi), or institutional support (ashraya)—may establish professional credibility; however, the physician endowed with all these qualities merits the designation vaidya and effectively promotes well being. (Cha. Su. 9/22–23). An explicit error prevention model is given where it is stated that shastra functions as illumination and buddhi as perception; a physician who coordinates both does not commit error in treatment (Cha. Su. 9/24). Since the other limbs depend on the physician, continuous effort toward enrichment of qualities is emphasized (Cha. Su. 9/25).[2]

3.7 Professional attitude: maitri, karunya, priti, upeksha

The text delineates a fourfold physician attitude (vaidya-vritti): friendliness (maitri), compassion toward the afflicted (karunya), commitment to treating remediable conditions (shakye priti), and equanimous detachment toward those approaching death (prakritistha bhuteshu upeksha). (Cha. Su. 9/26). This attitude set functions as an operational guidance for physician patient orientation across treatability states, integrating compassion with disciplined realism.[2]

3.8 Competence as a fourfold minimum: guna chatushtaya

Charaka reiterates physician primacy in chatushpada and specifies four essential qualities: clarity in learned knowledge (shruta paryavadatatva), repeated practical experience (bahusho drishta karmata), technical dexterity (dakshya), and purity (shaucha) (Cha. Su. 9/27; Cha. Su. 10/6). These form a concise competency minimum connecting knowledge, experience, skill, and discipline. [2,10]

3.9 Therapeutic causality and limits: treatment is effective where curable, but not universally reversible

The text rejects the claim that properly qualified therapy is causally ineffective in curable diseases, stating that therapeutic measures are not without effect in bheshaja sadhya conditions (Cha. Su. 10/5). Acknowledgement is apparent in recoveries without full therapy but asserts proper treatment accelerates and strengthens recovery; it is also mentioned that deaths despite treatment are also evident because not all diseases are upaya sadhya and the moribund state is not reversible even for the knowledgeable physician (Cha. Su. 10/5). The physician is described as acting after examination (parikshya) and accomplishing cure in curable disease when endowed with personal qualities and instruments (Cha. Su. 10/5). The trained archer analogy underscores precision through knowledge and practice (Cha. Su. 10/5).[10]

3.10 Clinical process discipline: examination, sequencing, context, and therapeutic governance

It is emphasized that treatment should begin only after understanding the nature of the disease, its site, and causative factors; action undertaken with such prior knowledge prevents confusion in practice (Cha. Su. 18/46–47). [5] It outlines a sequential clinical process, firstly examine the disease (roga pariksha), select appropriate medicine (aushadha), and then administer therapy with prior knowledge (Cha. Su. 20/20). When treatment is initiated without proper diagnosis, success occurs only by chance (yadrichchhaya), whereas assured success depends on disease specificity, therapeutic expertise, and attention to place, time, and measurement (desha, kala, pramana) (Cha. Su. 20/21–22).[6]

Charaka further underscores the necessity of physician intervention, questioning the need for treatment if disorders resolved naturally, thereby affirming the physician's role in restoring disequilibrium (Cha. Su. 16/30).[19] Clinical competence also includes timely application of core modalities like langhana, brimhana, rukshana, snehana, swedana, and stambhana, indicating that therapeutic timing is integral to success (Cha. Su. 22/4).[11]

The text extends this discipline into therapeutic governance by describing signs of adequate, inadequate, and excessive administration (yoga, ayoga, atiyoga), indicators of excessive morbidity, and principles governing both successful and complicated outcomes (Cha. Su. 16/39–41).[19] Together, these instructions emphasize dosing precision, clinical judgment, and physician responsibility in ensuring therapeutic safety and effectiveness. These directives collectively reflect a structured approach to patient safety, dosing regulation, and procedural accountability that parallels contemporary principles of clinical governance and quality assurance in healthcare.

3.11 Anti quackery safeguards and epistemic screening

Classification of physicians into three categories as chhadmachara (pseudo), siddhasadhita (pretender), and vaidya guna yukta/jivitabhisara (genuine) (Cha. Su. 11/50–53)is mentioned .[7] Behavioral markers of pseudo physicians are detailed such as self promotion, opportunistic patient pursuit, denigration of competent physicians, concealment of ignorance, fear of questioning, lack of verifiable lineage, and withdrawal before scholars (Cha. Su. 29/8–9). The text offers salutations to physicians who are learned in authoritative knowledge (shastravida), technically proficient (daksha), pure in conduct (shuchi), skilled in clinical practice (karma kovida), dexterous in procedures (jita hasta), and self-disciplined (jita atma). (Cha. Su. 29/10). [8]

Epistemic screening in debate is formalized for knowing the Physicians, where partial knowledge creates disturbance (Cha. Su. 30/72), and structured questioning (prashna ashtaka) is prescribed to assess competence (Cha. Su. 30/73–74). Further analogies distinguish genuine experts from pretenders and define traits of competent physicians (restraint in speech, humility, compassion,

commitment to refuting false arguments) versus frauds (dambha, excessive talk, irrelevant disputes) (Cha. Su. 30/75–81). Unqualified physicians aligned with false doctrines are to be avoided as shastra dushaka (Cha. Su. 30/82–83).[12]

3.12 Ethical formation and professional boundary regulation: physician pledge discipline

The text codifies physician formation through disciplinary instruction emphasizing celibate discipline (brahmacharya), truthfulness (satyavachana), purity (shaucha), selfrestraint (indriya-nigraha), adherence to teacherstudent discipline (gurushishya anuvartana), confidentiality, appropriate professional boundaries, contextual judgment, and refusal of unethical contexts of care**.**(Cha. Vi. 8/13). Importantly, ethical discipline is not separated from competence; it is framed as necessary to preserve therapeutic reliability, trust, and professional integrity. [13]

3.13 Scholarly discourse as competence maintenance

The text emphasizes discussion with physicians (tadvidya sambhasha) as essential: it advances knowledge pursuit, sharpens expertise, strengthens articulation, enhances fame, resolves doubts through repetition, reinforces conviction, and introduces new understandings (Cha. Vi. 8/15). Scholarly exchange is presented as a mechanism through which teacher-transmitted knowledge consolidates and becomes operational.[13]

3.14 Physician reasoning ecology: prior knowledge, pariksha, self-assessment, and adaptive judgment

In Viman sthan of the text it is mentioned that all action should be initiated with prior knowledge (gyana purvaka karma arambha) and enumerates an extended causal operational chain (karana/karana, karya yoni, karya, karya phala, anubandha, desha, kala, pravritti, upaya) as necessary for efficient outcomes (Cha. Vi. 8/56). It is mandatory for examination of ten factors (dasha vidha parikshya bhava) before action (Cha. Vi. 8/79; Cha. Vi. 8/84) along with physician self examination with assessment of personal capacity and required qualities before initiating treatment (Cha. Vi. 8/86). Finally, adaptive judgment is formalized where suitable drugs may be added even if unenumerated, unsuitable ones excluded even if listed; combinations may be made through reasoning validated by pramana (Cha. Vi. 8/149). This cluster presents a mature physician model with reasoning driven, examined, self-aware, and flexible within principled constraints.[13]

3.15 Prognostic discipline and refusal logic: Indriya Sthana governance

Charaka states that accurate knowledge of indriya vigyana enables discernment of life from death (Cha. In. 4/27),[14] and familiarity with severe premonitory signs and ominous dreams prevents initiation of therapy in incurable conditions due to ignorance (Cha. In. 5/47).[15] Advise for refraining from treatment when paradoxical signs of ayoga atiyoga coexist (Cha. In. 11/22).[16] Prognostic assessment extends to the messenger (duta) where specific abnormal appearances and untimely arrival indicate impending death and should lead to refusal (Cha. In. 12/9–11). The physician is instructed to refrain from accepting cases with death signs (Cha. In. 12/64), but to declare recovery when opposite signs are present, including auspicious indicators in the messenger, patient pathway, household context, patient conduct, and availability of appropriate medicines (Cha. In. 12/65–66).[17] This constitutes a bidirectional responsibility of refusal and affirmation are both governed by disciplined prognostic cognition.

3.16 Treatability-based decision structure and contextual refusal

It is stated to abandon asadhya, sustain yapya, and treat sadhya attentively using established remedies (Cha. Ni. 2/27).[4] Further specifies of refusal logic based on patient context risks even timely therapies should not be administered to cases defined by ethical noncompliance, lack of support, severe depletion, incurability, or fatal signs, as this yields papa and ayasha to the physician (Cha. Vi. 3/45).[18] This establishes refusal not merely as prognostic but as clinical contextual governance.

Table 1. Conceptual Framework of Physician Centred Principles in the Charaka Samhita

Macro Domain	Core Constructs	What the Text Operationalizes	Key References (Charaka)
Competence Formation & Professional Qualification	life-giver status (pranada); therapeutic success (siddhi); correct application (samyak prayoga); memory (smriti); causal reasoning (hetu yuktigyana); selfcontrol (jitatma); presence of mind (pratipattiman); learning clarity (shruta paryavadatatva); experiential competence (drishta karmata); technical skill (dakshya); purity (shaucha); life-promoting physician (pranabhisara); fourfold disease knowledge (chaturvidha gyana)	Physician legitimacy emerges from sustained self-development, cognitive competence, ethical discipline, and validated clinical outcomes	Su. 1/133–135; Su. 2/36; Su. 9/18–19; Su. 9/27; Su. 10/6; Sha. 4/44
Therapeutic Reasoning & Clinical Method	four limbs of treatment (chatushpada); primary causal agent (pradhana karana); components of treatment (chikitsa anganam); knowledge authority (shastra); intellect (buddhi); physician-guided therapy (vaidyavyapashraya); restoration of imbalance (vishama dhatu samikarana); adequate/inadequate/excess application (yoga, ayoga, atiyoga); therapeutic rationale (yukti chikitsayam); disease nature (vikara prakriti); site (adhisthana); etiological specificity (samutthana vishesha); disease examination (roga pariksha); medicine (aushadha); place, time, measurement (desha, kala, pramana); core modalities (langhana, brimhana, rukshana, snehana, swedana, stambhana)	Treatment success depends on physician-guided reasoning, proper sequencing, contextual judgment, and correct therapeutic timing	Su. 9/12–13; Su. 9/24–25; Su. 16/30; Su. 16/39–41; Su. 18/46–47; Su. 20/20–22; Su. 22/4; Su. 25/40
Ethical Conduct & Professional Discipline	friendliness (maitri); compassion (karunya); commitment to the treatable (priti); detachment toward the terminal (upeksha); moral restraint (brahmacharya); truthfulness (satyavachana); confidentiality	Ethical discipline and regulated conduct ensure trust, safety, and relational responsibility in care	Su. 9/26; Vi. 8/13

Regulation of Medical Authority & Anti-Quackery Safeguards	ignorant physician (ajna bhishak); chance success (yadrichchhaya); pseudo physician (chhadmachara); pretender (siddhasadhita); genuine physician (jivitabhisara); deceptive physician attire (vaidya vesha); debate screening (prashna ashtaka); fragmentary knowledge (shabda matra gyana); pretension (dambha); excessive talk (mukharata); false doctrine (asat paksha); destroyer of science (shastra dushaka); complete knowledge (gyana-vigyana purna); learned physician (shastravida); procedural skill (karma kovida)	The text establishes safeguards to distinguish competent physicians from impostors through knowledge standards, behavioral markers, and epistemic screening	Su. 9/16–17; Su. 11/50–53; Su. 29/8–10; Su. 30/72–83
Prognostic Governance & Treatment Boundaries	curable (sadhya); manageable (yapya); incurable (asadhya); moral fault (papa); professional disrepute (ayasha); moribund signs (mumursha lakshana); prognostic knowledge (indriya vigyana); premonitory signs (purvarupa); ominous dreams (daruna svapna); messenger indicators (duta lakshana); death signs (marana linga); recovery indicators (arogya linga)	Treatment decisions are governed by prognosis, ethical risk, and recognition of signs indicating futility or recovery	Ni. 2/27; Vi. 3/45; In. 4/27; In. 5/47; In. 11/22; In. 12/9–11; In. 12/64–66
Scholarly Development & Reasoning Ecology	scholarly dialogue (tadvidya sambhasha); expertise development (vaisharadya); articulation skill (vachana shakti); prior knowledge (gyana purvaka); examination (pariksha); tenfold evaluation (dasha vidha); reasoning processes (uha, apoha, vitarka); systemic body knowledge (sharira gyana); complete knowledge of Ayurveda (ayurveda kartsnata); freedom from confusion (moha abhava)	Physician competence is sustained through dialogue, examination, reasoning, and comprehensive knowledge of the body and science	Vi. 8/15; Vi. 8/56; Vi. 8/79; Vi. 8/84; Vi. 8/86; Vi. 8/149; Sha. 6/19; Sha. 7/19

Domains were derived through thematic clustering of physician related concepts and mapped to verse clusters to preserve textual traceability. The framework highlights the integration of clinical reasoning, ethical regulation, and professional accountability within Charaka's model of medical practice. Only sthan in abbreviated form is compiled in table as all sources belong to Charak Samhita. (Table 1)

4. Discussion

Across the five units of Charaka Samhita, it presents a clear and layered model of the physician. A physician's identity is built through continuous development and proven clinical outcomes, while the right to practice depends on possessing appropriate knowledge, reasoning ability, self-control, and responsible conduct.[1,4];Therapeutic causality is hierarchical, with the physician as pradhana karana integrating other limbs.[2,3] Clinical success is predicted to arise from examination, reasoning, sequencing, and timing rather than chance. [5,6,11,19] Safeguards are explicit, including antiquackery

classifications, debate screening, and behavioral markers [7,8,12]; boundary and discipline are codified as integral to physician formation and safe practice [13]; and prognostic governance controls acceptance or refusal and communication [14,15,16,17] Charaka treats "chance success" as diagnostically meaningless for physician quality, yadrichchhaya is explicitly invoked as the marker of nonknowledge based practice, with predictable risk to those with uncertain lifespan [2]. In parallel, siddhi is framed as the evidence of correct application rather than luck [1]. This internal logic positions physician as an accountable grounded in method, examination, and disciplined conduct.

5. Conclusion

Charaka Samhita constructs the physician as the primary integrating cause of treatment, defined by their cognitive behavioral qualifications, disciplined conduct, reasoning based therapeutic approach, and validated outcomes. Physician excellence is operationalized as disease removal, while treatment success (siddhi) functions as the indicator of correct application and accomplished Physician. Anti quackery doctrines, debate screening, refusal governance, and prognostic discipline collectively protect chikitsa from chance based practice and socially harmful imposture. In aggregate, the text offers a physician model that is competence centered, method governed, and outcome accountable within its own epistemic framework.

Declarations

Author Contributions Authors equally conceptualized the study, conducted textual analysis, performed thematic synthesis, and prepared the manuscript.

Funding No external funding was received for this study.

Conflict of Interest The author declares no conflict of interest.

Ethical Approval This study is based on classical textual analysis and does not involve human participants, animals, or clinical data; therefore, ethical approval was not required.

Informed Consent Not applicable.

Data Availability Statement All data analyzed in this study are derived from publicly available classical Ayurvedic texts and are included within the article.

Abbreviations

In this article, Cha.Su. denotes Charaka Samhita, Sutra Sthana; Cha.Ni. denotes Charaka Samhita, Nidana Sthana; Cha.Vi. denotes Charaka Samhita, Vimana Sthana; Cha.Sha. denotes Charaka Samhita, Sharira Sthana; and Cha.In. denotes Charaka Samhita, Indriya Sthana. The abbreviated forms Su., Ni., Vi., Sha., and In. are used to indicate Sutra, Nidana, Vimana, Sharira, and Indriya Sthana respectively.

References

1. Singh R.H., Singh G., Sodhi J.S., Dixit U.. (2020). Deerghanjiviteeya Adhyaya. In: Dixit U., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.3). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.003
2. Tomar G.S., Kumar N.. (2020). Khuddakachatushpada Adhyaya. In: Dixit U., Deole Y.S., Basisht G., (Eds.), Cha'rak Samhita New Edition (1st ed. pp.11). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.011
3. Dwivedi B.K., Deole Y. S.. (2020). Yajjah Purushiya Adhyaya. In: Dwivedi R.B., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.27). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.027
4. Nesari T., Mallya S., Sawant B.. (2020). Apamarga Tanduliya Adhyaya. In: Sawant B., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.4). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.004

5. Prasad R., Deole Y. S.. (2020). Trishothiya Adhyaya. In: Kar A., Rai S., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.20). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.020
6. Byadgi P.S., Saini N.. (2020). Maharoga Adhyaya. In: Kar A.C., Rai S., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.22). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.022
7. Tiwari P.. (2020). Tistraishaniya Adhyaya. In: Dixit U., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.13). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.013
8. Manohar P.R.. (2020). Dashapranayataneeya Adhyaya. In: Patwardhan K., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.31). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.031
9. Singh R.H., Sodhi J.S. (2020). Sroto Vimana Adhyaya. In: Pol A., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.47). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s03.006
10. Chandola H.M., Kajaria D.. (2020). Mahachatushpada Adhyaya. In: Dixit U., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.12). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.012
11. Murthy K.N., Deole Y. S.. (2020). Langhanabrimhaniya Adhyaya. In: Dwivedi R.B., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.24). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.024
12. Patwardhan K., Upadhyaya W.. (2020). Arthedashmahamooliya Adhyaya. In: Dwivedi R.B., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.32). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.032
13. Dubey S.D., Singh A.N., Singh A., Singh A., Samant A., Deole Y. S.. (2020). Rogabhishagjitiya Vimana Adhyaya. In: Khandel S.K., Bhagwat M., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.50). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s03.009
14. Khandel S.K., Rai S.. (2020). Indriyaneekam Indriyam Adhyaya. In: Khandel S.K., Babu S.P., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.64). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s05.005
15. Godatwar P., Sharma R.. (2020). Purvarupeeyam Indriyam Adhyaya. In: Khandel S.K., Babu S.P., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.65). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s05.006
16. Pandya D.. (2020). Anujyotiyam Indriyam Adhyaya. In: Khandel S.K., Babu S.P., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.71). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s05.012
17. Pandya D.. (2020). Gomayachurniyam Indriyam Adhyaya. In: Khandel S.K., Babu S.P., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.72). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s05.013
18. Nishteswar K.. (2020). Janapadodhvansaniya Vimana Adhyaya. In: Pol A., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.45). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s03.004
19. Murthy A.R.V., Magare R.. (2020). Chikitsaprabhritiya Adhyaya. In: Mangalasseri P., Deole Y.S., Basisht G., (Eds.), Charak Samhita New Edition (1st ed. pp.18). CSRTSDC. https://doi.org/10.47468/CSNE.2020.e01.s01.018