

## **Prognosis, Professional Judgment, and the Limits of Treatment in Classical Indian Medicine**

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**Abstract:** *This paper examines how classical Indian physicians decided not only when to treat illness, but also when to stop treatment. It challenges the view that Āyurveda stood between empirical medicine and astrological fatalism. Instead, it argues that temporal and prognostic reasoning functioned as a kāla-based framework for assessing medical risk rather than as a direct cause of disease. Focusing on the Caraka Saṃhitā and its eleventh-century commentator Cakrapāṇidatta, the paper shows that medical judgment was grounded in yukti, the coordinated use of observation, inference, and authoritative knowledge. Seasonal and environmental factors shaped the conditions of illness but did not override clinical reasoning. Central to the argument is ariṣṭa-lakṣaṇa, understood as a systematic form of prognosis that guided physicians in recognizing when disease had moved beyond effective treatment. By framing withdrawal from therapy as a reasoned clinical decision rather than a failure, the paper shows that recognizing the limits of treatment was an essential part of professional judgment in classical Indian medicine.*

**Keywords:** *Āyurveda, Ariṣṭa-lakṣaṇa, Professional Judgment prognosis, Yukti etc.*

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### **Introduction**

The historiography of pre-modern Indian medicine has often relied on a false opposition. Ayurvedic practice is commonly described either as an early form of secular, empirical medicine or as a system shaped by astrological fatalism.<sup>1</sup> This binary, largely inherited from colonial ways of classifying knowledge, obscures the intellectual context in which the classical medical *Saṃhitās* were composed and practiced. For the ancient *vaidya*, the recognition of *daiva* (cosmic or inherited factors) alongside *mānuṣa* (human agency) did not

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signal a turn toward superstition. Instead, it helped define the practical and ethical limits of medical intervention. As the *Caraka Saṃhitā* repeatedly states, disease arises from the conjunction (*samyoga*) of multiple factors—bodily condition, time (*kāla*), and past action—rather than from a single cause.<sup>2</sup>

Within this plural causal framework, therapeutic success depended on whether these factors aligned in a way that made intervention effective. Causality in classical Āyurveda thus functioned less as an abstract theory and more as a tool of clinical judgment. It guided physicians not only in deciding how to treat illness, but also in recognizing when continued treatment was no longer justified.

As Kenneth G. Zysk has shown, classical Indian medicine emerged in close dialogue with heterodox ascetic traditions, where healing knowledge developed outside Brahmanical ritual authority and was grounded in observation, debate, and demonstrable efficacy rather than sacrificial practice.<sup>3</sup> Within the medical texts themselves, health is presented as the basis of *dharma*, *artha*, *kāma*, and *mokṣa*, while illness appears as a practical obstacle to human flourishing.<sup>4</sup> Disease was therefore understood not as ritual impurity, but as a disruption of life's aims, encouraging physicians to develop a discipline oriented toward restoring balance rather than performing symbolic purification.

This paper intervenes in three related strands of scholarship. First, it challenges readings that treat Āyurveda either as an early form of empirical naturalism or as a system compromised by astrological fatalism, arguing that both positions misunderstand how causality and time operated in medical reasoning. Second, it questions interpretations that treat astral and cosmological knowledge as direct explanations of disease, showing instead that such knowledge served mainly as a framework for assessing temporal and environmental risk. Finally, it revises accounts of medical rationality that equate professional authority solely with therapeutic success, demonstrating that classical Āyurveda formally recognized withdrawal from treatment as a rational and regulated outcome of clinical judgment.

Building on this approach, the paper argues that prognostic reasoning in classical Indian medicine functioned as a form of professional triage. By assessing bodily signs, temporal conditions, and response to therapy, physicians were authorized not only to select appropriate treatments but also to decide when withdrawal was necessary, especially once disease had moved beyond effective control. As Gerrit Jan Meulenbeld has shown, the *Caraka* tradition

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draws on diverse philosophical systems while consistently subordinating them to medical reasoning, affirming the physician's duty to distinguish between curable and incurable conditions.<sup>5</sup> Withdrawal from treatment did not weaken medical authority; it clarified the limits of rational therapy and protected professional credibility. By separating restraint from failure, classical medicine made the recognition of limits a core element of clinical reasoning, embedded within the normative structure of the Sanskrit medical corpus itself.<sup>6</sup>

## The Scholastic Laboratory — Cakrapānidatta and the Bengali Synthesis

By the eleventh century, eastern India under the Pāla rulers had become an important centre of scholastic activity, marked by sustained commentarial writing and interaction among medical, logical, and cosmological traditions.<sup>7</sup> This setting produced a class of physician-scholars whose authority rested not simply on transmitting canonical texts, but on interpretation, debate, and the refinement of medical knowledge. Medical authority was therefore not guaranteed by lineage alone; it had to be maintained through active scholarly engagement and critical reasoning.

A key figure in this milieu was Cakrapānidatta, whose *Āyurvedadīpikā* was more than a conventional commentary on the *Caraka Saṃhitā*. Drawing selectively on forms of reasoning associated with Nyāya, he worked to clarify the relative authority of different sources of knowledge, resolve textual ambiguities, and relate inherited medical doctrines to later philosophical discussion.<sup>8</sup> His approach reflects a wider scholastic tendency to treat the medical corpus not as a closed canon, but as a body of knowledge open to rational examination and contextual interpretation.

Within this framework, reliable medical knowledge was understood to arise from the coordinated use of authoritative testimony (*āptopadeśa*), direct perception (*pratyakṣa*), and inference (*anumāna*). Authority rested on trustworthy sources, while perception and inference depended on disciplined observation and reasoning. Clinical judgment was considered valid only when all three *pramāṇas* were brought together; no single source of knowledge was sufficient on its own.<sup>9</sup> This epistemic structure placed the *vaidya* in an active role, requiring the synthesis of multiple forms of evidence rather than the passive acceptance of inherited doctrine.

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Cakrapāṇidatta's commentary is especially important for understanding the role of inference in diagnosis and prognosis. He makes explicit what is only implicit in the base text: that prognostic reasoning is not secondary to treatment, but a core element of medical judgment. Through inference, physicians moved from observable signs—such as loss of strength, changes in complexion, or diminished sensory response—to conclusions about underlying disease processes and likely outcomes, including the recognition of incurability. Inference thus worked alongside observation and authoritative knowledge, extending clinical judgment beyond what perception alone could show while remaining anchored in visible signs.<sup>10</sup>

This Bengali scholastic synthesis allowed physicians to maintain professional autonomy without rejecting cosmological knowledge altogether. Astral and divinatory frameworks associated with texts such as the *Bṛhat Saṃhitā* were mainly treated as temporal and classificatory systems for assessing vulnerability (*kāla-vicāra*), rather than as forces that directly determined clinical outcomes.<sup>11</sup> By placing such knowledge under the authority of clinical reasoning, scholastic medicine preserved flexibility in therapeutic decision-making while maintaining broader cosmological coherence. This synthesis marked the development of classical Indian medicine into a disciplined system capable of balancing canonical authority, empirical observation, and contextual reasoning without surrendering medical judgment to cosmological determinism.<sup>12</sup>

## Environmental Periodicity and Medical Risk-Astronomy as a Kāla-Based Framework

In classical Indian medical thought, the macrocosm was understood not as a source of occult intervention, but as a domain governed by regular temporal patterns (*kāla-niyama*). Astronomical texts such as the *Vedāṅga Jyotiṣa* developed systematic ways of measuring time by organizing the year into *ṛtu*, *āyana*, *tithi*, and *nakṣatra*, creating a stable framework for understanding seasonal change.<sup>13</sup> Drawing on this temporal structure, the *Caraka Saṃhitā* integrates seasonal time into medical reasoning by linking diet, daily regimen, and bodily processes to cyclical environmental variation. The year is divided into six seasons, arranged into the alternating phases of *ādāna* and *visarga* according to the sun's movement, and bodily strength is understood to depend on adjusting conduct and nourishment to these rhythms.<sup>14</sup>

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Within this framework, planetary movements were not treated as direct causes of disease. Instead, they served as indicators (*sūcaka*) of broader environmental conditions—such as patterns of wind, humidity, and solar intensity—that shaped period of increased bodily vulnerability. Engagement with texts such as the *Bṛhat Saṃhitā* therefore functioned as a form of medical risk assessment rather than divination. Varāhamihira’s discussions of rainfall, winds, and vegetation link celestial patterns to changes in water quality, agricultural conditions, and the availability of medicinal resources.<sup>15</sup> These correlations allowed physicians to place individual illness within a wider temporal and ecological context and to adjust treatment in response to changing conditions of time (*kāla-avasthā*), rather than according to fixed or deterministic expectations.

Modern scholarship has shown that this focus on celestial and environmental correlation positioned *jyotiḥśāstra* as a predictive discipline concerned with seasonal and ecological change, grounded in calculation, observation, and calendrical order rather than speculative metaphysics.<sup>16</sup> For medical practitioners, astronomical knowledge thus provided a temporal framework for assessing bodily processes without displacing the primacy of clinical observation and judgment. In this way, astronomy helped identify periods of environmental risk while leaving therapeutic decision-making firmly with the physician. While similar forms of seasonal risk assessment appear in Greco-Roman and Islamic medicine, classical Āyurveda is distinctive in the systematic way it integrated temporal knowledge directly into clinical reasoning rather than treating it as external prognostication. Classical Indian medicine could therefore acknowledge ecological constraints without surrendering clinical authority.<sup>17</sup>

## The Hierarchy of Evidence — Clinical Primacy and the Limits of *Daiva*

While environmental and temporal factors shaped the broader setting in which illness developed, the clinical encounter itself was governed by a clear hierarchy of evidence that gave priority to observable bodily signs over cosmological considerations. In the *Caraka Saṃhitā*, medical reasoning rests on the principle that inference must be grounded in direct perception (*pratyakṣa-pūrvakam anumānam*).<sup>18</sup> Even when prognostic signs appeared unfavourable, physicians were instructed to rely first on empirical indicators—such as bodily

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strength, complexion, sensory clarity, vitality, and responsiveness to treatment—so long as these suggested the possibility of recovery.<sup>19</sup> Clinical judgment therefore remained anchored in what could be directly observed and assessed in the body.

This ordering of evidence did not mean that non-material factors such as *daiva* or *kāla* were denied. Rather, they were placed under the authority of trained clinical observation. Medical reasoning in the *Caraka Saṃhitā* operates through a multi-causal logic in which outcomes arise from several interacting factors over time. *Yukti* is defined as rational knowledge that coordinates these causes and directs treatment toward achievable results rather than speculative aims.<sup>20</sup> When different explanations came into tension, those accessible through perception and inference were given priority, ensuring that cosmological or temporal considerations did not override clinically verifiable evidence.

The clinical discussions of the *Indriyasthāna* show how this hierarchy worked in practice. Physicians were instructed to observe specific bodily signs—such as persistent loss of strength despite nourishment, abnormal changes in skin colour, impaired sensory response, and severe depletion of vitality—as indications that disease had moved beyond reversible imbalance. These signs were not treated as omens, but as empirically readable markers of bodily decline. When such indicators accumulated and failed to respond to rational therapy, the physician was authorized to infer incurability (*asādhyatā*) and to reconsider the continuation of treatment.<sup>21</sup> Prognostic judgment thus emerged from the combined assessment of multiple observable signs rather than from any single indicator.

This hierarchy of evidence preserved a protected space for clinical judgment. While environmental conditions and temporal rhythms formed the background of illness, decisions about cure and its limits remained grounded in *yukti*, understood as the reasoned coordination of observation and therapeutic action. Surgical practice further illustrates this priority, as it depended on anatomical knowledge, manual skill, and direct sensory engagement with the body. By distinguishing environmental risk from clinical reality as revealed through bodily signs, classical Indian medicine ensured that decisions about treatment and restraint rested on disciplined observation rather than ritual or divinatory mediation.<sup>22</sup>

## Professional Triage- *Ariṣṭa-lakṣaṇa* and the Ethics of Withdrawal

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The limits of clinical intervention are most clearly expressed in the doctrine of *ariṣṭa-lakṣaṇa*, the prognostic signs of impending death described in the *Caraka Saṃhitā*. Although these signs have often been read as expressions of fatalistic belief, Meulenbeld has shown that within classical Indian medicine they functioned as a structured system of prognosis. This system guided physicians in recognizing when disease had moved beyond effective therapeutic control and when withdrawal from treatment was medically justified.<sup>23</sup> Rather than weakening medical agency, *ariṣṭa-lakṣaṇa* provided an authorized and methodical way to acknowledge the limits of rational intervention.

The *Caraka Saṃhitā* is explicit about the professional consequences of ignoring these limits. A physician who undertakes the treatment of an incurable (*asādhya*) condition is said to suffer loss of wealth, learning, and reputation (*artha-nāśaḥ kīrti-nāśaś ca*), showing that medical failure was understood not only in bodily terms but also within a wider social framework of professional credibility.<sup>24</sup> In a medical culture where authority depended on demonstrable efficacy, physicians therefore needed a clear and socially recognized basis for declining treatment in terminal cases without undermining trust in medical practice.<sup>25</sup> Withdrawal in this context did not imply neglect or resignation; it served to protect clinical judgment in situations of irreversible decline.

Classical physicians further refined this process by classifying *ariṣṭa-lakṣaṇa* according to the expected closeness of death, creating a graded prognostic framework that regulated whether treatment should continue or cease. This allowed for conditional care, repeated reassessment, and the withdrawal of intervention after sustained non-response to therapy.<sup>26</sup> Such regulation did not lessen ethical responsibility. Instead, it clarified the boundary between curable (*sādhya*) conditions and cases that lay beyond effective treatment. Proper medical judgment therefore included recognizing the point at which further intervention could no longer produce meaningful results.<sup>27</sup> Taken together, the doctrines of prognosis and incurability established a shared clinical threshold beyond which non-intervention was not a failure of reasoning, but an ethically and professionally sanctioned outcome embedded in the normative structure of classical medical practice.

## Theoretical Implications — Rethinking Medical Rationality in Classical India

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The medical practice examined in this study challenges accounts of medical rationality that treat it as a gradual separation between nature and culture, or between empirical observation and cosmological thought. Classical Indian medicine did not develop by excluding environmental or temporal factors. Instead, it integrated them through clear hierarchies of evidence and the reasoned use of *yukti*. Time (*kāla*) and environment shaped the setting in which illness unfolded, but they functioned as contextual conditions rather than determining forces that displaced clinical judgment grounded in observation and inference.

From this perspective, the ancient *vaidya* did not operate within a pre-scientific or fatalistic framework. Medical judgment rested on calibrated reasoning: the coordination of authoritative testimony, direct perception, and inference, together with careful attention to the limits of therapeutic effectiveness. Rationality was expressed not only in successful treatment, but also in recognizing when continued intervention no longer fell within the bounds of reasoned medical practice.<sup>28</sup>

Classical Indian medicine therefore offers a historically grounded model of medical rationality in which restraint was integral to professional judgment rather than a secondary ethical concern. By treating prognosis, incurability, and withdrawal as legitimate outcomes of clinical reasoning, the tradition made the recognition of limits a defining feature of rational practice. Medical reasoning was defined not only by the capacity to act on the body, but equally by the ability to decide when further intervention had reached its proper limit.

## Prognosis, Professional Limits, and the Rationality of Restraint

The analysis developed in this study suggests that *ariṣṭa-lakṣaṇa* should be understood not as a residual form of belief, but as a formal mechanism for preserving medical rationality under conditions of prognostic uncertainty. By enabling physicians to identify the point at which treatment ceased to be effective, classical Āyurveda built professional restraint directly into clinical reasoning. Prognosis thus functioned as a regulatory practice, aligning therapeutic action with achievable outcomes while protecting both patient well-being and the integrity of medical practice.

This logic was not unique to South Asia, though it was articulated with particular clarity in the classical Sanskrit medical tradition. Across premodern medical cultures,

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physicians faced the problem of distinguishing therapeutic failure from the inherent limits of medicine. What distinguishes the Ayurvedic approach is the explicit integration of this distinction into *yukti*—the coordinated use of observation, inference, and authoritative knowledge—rather than leaving it to moral discretion, ad hoc judgment, or retrospective explanation. Prognosis was therefore not secondary to therapy, but a central component of medical reasoning.

What was at stake in this integration was not only epistemic coherence, but also professional trust. Repeated warnings about the loss of wealth, learning, and reputation show that medical authority operated within a shared social framework of expectation and accountability. Prognostic withdrawal thus functioned as an implicit professional contract: by discontinuing treatment once rational limits were reached, physicians protected patients from futile intervention while preserving the collective credibility of medical practice.<sup>29</sup> In this context, restraint was not simply an individual ethical choice, but a socially recognized and professionally responsible act.

Seen in this light, withdrawal from treatment appears as an expression of disciplined judgment rather than resignation or failure. Medical rationality lay not only in the ability to act upon the body, but equally in the capacity to recognize when further intervention no longer served the aims of reasoned medical practice. By institutionalizing this recognition, classical Indian medicine articulated a model of rational authority in which knowing when not to act was as central to professional competence as knowing how to heal.

## Conclusion

Classical Indian medicine was neither a surrender to cosmic fatalism nor an early form of reductive materialism. Instead, it articulated a model of medical reasoning in which environmental and temporal factors shaped the context of illness without displacing the primacy of clinical judgment. Diagnosis and treatment were grounded in observation, inference, and rational synthesis (*yukti*), while prognosis marked the point at which intervention remained medically justified.

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This study shows that medical authority in the *Caraka* tradition did not rest solely on the ability to cure. It rested equally on the physician's capacity to recognize incurability and to withdraw from treatment when rational limits were reached. The eleventh-century scholastic synthesis associated with Cakrapānidatta strengthened this authority by refining hierarchies of evidence and formalizing the distinction between curable and incurable conditions. Withdrawal from treatment was thus not a failure, but a reasoned and professionally sanctioned act.

Seen in this way, classical Indian medicine offers a model of medical rationality in which restraint was integral to competence rather than opposed to it. By treating prognosis, incurability, and justified non-intervention as core elements of practice, the tradition redefines medical authority as the disciplined ability to judge both when to act and when not to act.

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