Manussakama in Medicine

Letting Humanity Flow

A reflection on healthcare delivery, medical education, and the wisdom already present

A dialogue between a clinician and an AI

For like-minded colleagues. For those who already feel this.

2025

A Note Before We Begin

This document did not begin as a document. It began as a conversation. A doctor who has lived and worked in both Sri Lanka and Australia began to think out loud about healthcare, and what followed surprised both participants. This is not a policy paper. It is not a critique. It is not a reform agenda.

It is an attempt to name something that already exists. And to ask, gently and without agenda, what might happen if that something were allowed to flow a little more freely.

The tone throughout is humble. Deliberately so. Sri Lanka has a remarkable health system that achieves extraordinary outcomes on a fraction of the resources available to wealthy nations. Nobody here is in a position to teach Sri Lanka anything it does not already know. The aim is only to begin a dialogue that is already happening, in fragments, and to make it a little bolder and a little louder.

> *Dream small. Act local. Seek no credit. Trust the virus to spread.*

If any of this resonates, pass it on. If it does not, put it down. Either response is completely fine.

Part One: What Makes Care Reliably Decent?

We began not with deficiencies but with a question: what does a well-resourced system like Australia's do to ensure that most patients receive a minimally acceptable level of care, most of the time? Not the best care in the world. Just reliably decent care. The distinction matters enormously.

Four clinical stories helped us find the answer. Each story was deliberately ordinary. No heroic medicine. No cutting-edge technology. Just the quiet, invisible work of a system that has distributed its burden intelligently.

Story One: The Psychotic Patient and Anne

A patient being transferred to a secure psychiatric unit is paranoid about another patient, Anne, whom he has seen in the corridor. A consultation-liaison nurse, doing a routine risk assessment, makes a lateral connection: Anne frequently uses the cafe near the ED, raising the risk of repeated accidental encounters that could destabilise the patient and increase his absconding risk. She flags this to Anne's team leader and documents it with an alert in the electronic record.

No extraordinary clinical skill was required. What was required was bandwidth. The CL nurse had only one role: mental health patients outside the psychiatric unit. The team leader managed a caseload small enough to know her patients individually. The risk assessment form prompted the thinking. The electronic record carried the concern forward beyond the shift change.

> *The system made good care the path of least resistance.*

Story Two: Rita and the Dry Cough

Rita develops a dry cough after her cardiologist changes her antihypertensive. Her GP sends a brief additional referral noting the complaint. The cardiology triage nurse, finding this unusual, copies it to the clinic pharmacist. The pharmacist reviews the medication list and emails the cardiologist. The cardiologist, busy and initially inclined to overlook a minor complaint, is prompted by the flagged email to change the medication.

Left unaddressed, Rita might have quietly stopped her antihypertensives. A trivial cough potentially sitting upstream of a stroke. The system caught her through redundancy: multiple people in different roles, each catching what the other might miss.

Story Three: The Young Man with Chest Pain

A fit young man in his thirties presents to ED with chest pain. The ED doctor, anchored by the absence of risk factors, is dismissive. But the paramedics have already alerted triage to abnormal ECGs. The protocol requires a repeat ECG and troponin. The nurse reminds the doctor. A full MI is diagnosed.

Two threads emerged from this story. First, the physical resource infrastructure: a functioning ambulance ECG machine, trained paramedics, a laboratory resourced through the night. Second, the communication infrastructure: the paramedic's meaningful pre-notification, the nurse's reminder, the patient being kept informed of

what was happening and what would happen next. That narrative given to the patient was not a courtesy. It was medicine. A frightened, uninformed patient becomes a difficult patient, and a difficult patient in an overstretched system receives worse care.

Story Four: Who Tells the Patient?

The fourth story was less a narrative than an observation. A doctor performing his 473rd MI knows exactly what is happening. The patient does not. The question is whether the doctor tells him. In Australia, accountability structures make not telling the patient costly. AHPRA, complaints mechanisms, patient rights frameworks: these do not make dismissive doctors caring. They make dismissiveness costly. That is enough, most of the time.

In Sri Lanka, the doctor is venerated not merely as a clinical expert but as a moral and intellectual superior. The patient has internalised this so completely that they may not think to ask what is happening to their own body. The patient is a lesser participant in their own care. And that conditioning, on both sides of the relationship, is harder to dismantle than any resource deficit.

The Six Threads

From these stories, six threads emerged that describe what a reliably decent healthcare system does. These are not features of a wealthy system. They are features of a thoughtfully designed one.

Thread	What it means in practice
Capacity to notice	Workers have sufficient bandwidth to think laterally, make connections, and catch what is not immediately obvious. Good care is possible only when there is cognitive space for it.
Redundancy	Multiple people in different roles each catch what another might miss. No single point of failure. Care does not depend on any one person being exceptional.
Physical resource infrastructure	Equipment, supplies, and trained personnel are available when needed, including in the middle of the night. Each link in the chain holds.
Communication infrastructure	Information flows reliably between paramedic and triage nurse, between doctor and patient, between teams across shift changes. The patient has a narrative about what is happening to them.
Accountability and patient agency	Poor care carries consequences. Patients know they have rights. The structures that enforce this do not require virtuous clinicians — they incentivise the right behaviour regardless of the underlying attitude.
Role distribution and the allied health ecosystem	The burden of care — including patient and family education — is spread across many shoulders: pharmacists, educators, social workers, allied health professionals. No single clinician has to be everything.

Part Two: The Strengths of the Sri Lankan System

Having identified the threads of reliable care, we turned the lens around. Not to catalogue what Sri Lanka lacks, but to understand what it has. Because something remarkable is happening in Sri Lanka's health system. It achieves outcomes that health economists and policy makers have genuinely struggled to explain, on a fraction of the per capita health expenditure of wealthy nations. There is wisdom here that deserves to be named clearly.

Manussakama: The Ground Beneath Everything

The most important strength is the hardest to quantify. It is the depth of human connection that characterises Sri Lankan social life and flows naturally into clinical encounters. A Sri Lankan health worker does not see a consumer. She sees a person she feels viscerally responsible for. The way a parent feels responsible for a child.

This is not a romanticised or idealised quality. It is an existential reality of the average person in Sri Lanka. It produces a quality of attentiveness that no protocol can manufacture. The clinician who walks into a room and already knows, before any assessment, that something is deeply wrong with this person, not because a risk assessment form told her so, but because she looked at him the way you look at someone you love, is operating with a clinical instrument of extraordinary power.

> *Manussakama does not require time or resources. It requires only that you stop blocking it.*

The shadow side of this depth is real and must be named honestly. The same depth of connection, when it curdles, produces paternalism. The doctor who does not inform the patient because he has already decided what is best, the way a parent decides for a child. The nurse who is warm to the cooperative patient and cold to the one who resists. In a relationship framed as familial, the patient who does not behave like a grateful child can feel like a betrayal.

Manussakama is powerful and warm and utterly inconsistent. It is, in the most honest description available, highly inflammable.

Veneration as a Social Contract

The veneration of doctors and, to a lesser degree, other health workers in Sri Lanka functions as a surprisingly powerful quality driver. The community places the clinician on a pedestal and in return the clinician, even the difficult ones, feels compelled to deliver. Not necessarily out of virtue, but out of the need to maintain the social order that defines them. The social identity of the Sri Lankan doctor is built on the premise that he heals. To be seen to fail that premise is existentially threatening in a way that a formal complaint mechanism cannot replicate.

So even the angry doctor, even the resentful one, finds a way. Cobbles something together. Because the alternative is socially catastrophic.

The shadow side is equally real. When he cannot find a way, the excuse-making begins and it can be magnificent in its creativity. Veneration functions simultaneously as a quality driver and a truth suppressant.

The Freedom of Ungoverned Space

The absence of robust clinical governance, which would normally sit firmly in the deficiency column, creates an accidental freedom that can be extraordinarily productive. The clinician who wants to do something creative, something outside the usual pathway, something that his experience tells him is right for this particular patient, can simply do it. No protocol committee. No mandatory escalation pathway. No documentation burden that slows the decision to a crawl.

The patient arriving without a carried clinical record is also a patient arriving without carried prejudices. The man who was labelled a drug seeker at his last presentation gets a clean slate. The system's inability to carry prejudice forward is, accidentally, a form of justice.

But in a contained community, the absence of formal records does not mean the absence of memory. The informal label spreads through word of mouth, through handover conversations, through a raised eyebrow between colleagues. It is invisible. Unchallengeable. Undocumentable. The patient cannot see it, cannot contest it, cannot ask for it to be corrected.

The Refusal to Accept That Something Cannot Be Done

Sri Lanka's health system runs on improvisation. Equipment is repaired in ways that violate manufacturer guidelines and safety protocols because the only alternative is no equipment. Disposable gloves are washed and sterilised. Procedures are performed under conditions that would not be acceptable in a wealthy system. And then everybody moves on. No fanfare. No credit. Another day.

This quality has a particular cultural flavour. It is not merely improvisation. It is improvisation worn lightly. Done without self-congratulation, which is actually part of what makes it sustainable. It does not require recognition to keep going. It simply keeps going.

Some of what falls under this thread occupies genuinely grey ethical territory. Thin layers of lignocaine applied to a catheter rather than into the urethra. Conscious patients undergoing colonoscopy. One doctor and two nurses managing a violent psychiatric patient. These are not ideal. Everyone in the room knows they are not ideal. But the calculus is made, silently, practically: an imperfect procedure or a no procedure. And the patient, often, accepts this. Because there is a shared pragmatic understanding that this is how things get done here.

Summary: Two Different Kinds of Genius

Australian System	Sri Lankan System
Distributes burden across structure	Concentrates burden on individuals
Good care is the path of least resistance	Good care requires consistent effort
Reliability through redundancy	Reliability through human commitment
Accountability is external and structural	Accountability is internal and social

Patient is an autonomous agent	Patient is a person in a relationship
Humanity is professional; connection is boundaried	Humanity is natural; connection is deep
Improvisation is a failure mode	Improvisation is a survival skill

Neither system is superior. Each carries risks the other is protected from. Each compensates for what the other lacks.

Part Three: Barriers to the Dialogue

The question we arrived at was not how to make Sri Lanka more like Australia. That framing would require dismantling Sri Lanka first, and what emerged in its place would be neither Sri Lankan nor Australian, and almost certainly worse than both. The question was more specific and more humble: what are the barriers to an honest, productive dialogue about how to ensure that fewer patients fall through the cracks?

The Tyranny of Ideal Conditions

Perhaps the most insidious barrier is a phrase embedded in medical education: ideal conditions. Students are taught how procedures should be performed, how conversations should be conducted, how notes should be written, under ideal conditions. The implication, never stated but always present, is that the Sri Lankan clinical reality is a temporary, inferior, apologetic space. The doctor is always practising medicine in the meantime. Until the ideal conditions arrive. Which they never do.

The shame this produces is profound. A doctor ashamed of her conditions cannot think creatively within them. She is too busy mourning what she does not have to fully inhabit what she does. She sees her practice as a lesser version of real medicine practiced somewhere else.

The reframe is simple but radical: there are no ideal conditions. There is only this patient, this moment, this conversation, and you. These are your conditions. They are not inferior conditions. They are your conditions. What is the most intelligent and humane thing you can do right now, with exactly what you have?

The Colonial Inheritance of Shame

The belief that native knowledge, native language, native instinct, is lesser runs deeper than any individual can trace. It was planted during colonial rule and has been quietly maintained by a medical education system that teaches in a borrowed language, references borrowed frameworks, and implicitly asks the student to set aside the cultural intelligence that makes her potentially extraordinary in her specific context.

A medical student who must first think in her mother tongue, then translate into English to write the answer, then translate back into her mother tongue to speak to her patient, is carrying a cognitive and emotional burden that her Western counterpart never has to imagine. And somewhere in all that translation, the native clinical wisdom gets lost.

Allowing mother tongue examination answers is not a lowering of standards. It is a liberation of intelligence. This is not a call for an immediate systemic reform. It is a seed. A conversation to begin, quietly, in the doctors' lounge.

The Belief That Change Has to Be Grand

The impulse to write the definitive book, to convene the committee, to launch the reform agenda, is understandable. But in the Sri Lankan context it is counterproductive. Change imposed from above, or from someone who appears to be claiming superior knowledge, triggers the veneration dynamic in reverse. The same cultural current that makes veneration a strength becomes a wall of collective defensiveness. The bold book angers colleagues. The midline incision rate rises.

The alternative is to dream small and act local. Begin one conversation in the doctors' lounge. Not a lecture. Not an implied accusation. Just a colleague saying to another: I have been thinking about these midline scars. What do you think? That conversation has no enemy. Nobody's pride is threatened. The seed is planted and the planter moves on without credit. And the seed grows in its own time.

The Veneration of the Clinician as a Barrier to Patient Agency

The very cultural dynamic that drives quality also suppresses honest dialogue between clinician and patient. A patient who has internalised their own inferiority does not ask questions. Does not challenge. Does not report poor care. Does not even register, sometimes, that poor care has occurred. And a system without genuine patient voice cannot improve, because it cannot hear what is going wrong.

This is perhaps the most difficult barrier of all, because it requires change on both sides simultaneously. The clinician must begin treating the patient as an equal participant in their own care. And the patient must begin to believe that they deserve to be one. Each change makes the other more possible. But neither can wait for the other to go first.

Part Four: Innovations Worth Naming

Several practical innovations emerged from the dialogue. They are offered not as prescriptions but as starting points for conversation. Each is small enough to begin tomorrow. Each is consistent with the dream small, act local philosophy.

The Minimal Meaningful Clinical Note

Sri Lankan doctors do not have the luxury of lengthy clinical notes. The typical entry in a busy outpatient clinic may be only a few words. This is a constraint that cannot be wished away. But within that constraint, there is room for one additional act: a forward-looking notation.

A patient mentions a new dry cough. The doctor is not ready to change the medication today, but is mildly concerned. The note does not need to document a full medication review. It needs only to say: Ask about cough next time. Or even: Cough. Review. The next doctor sees this. The patient does not fall through the crack.

This is not a new documentation system. It is a small shift in the purpose of the note, from recording what happened to also flagging what needs attention next. It requires no additional time. It requires only the habit.

Q&A as Patient Education

The standard model of patient education, the clinician explaining to the patient what is wrong and what to do, is inefficient and often ineffective. It wastes the knowledge the patient already has. It produces passive recipients of information rather than active participants in their care.

A more efficient and more respectful model begins with a question: what do you think is happening? The patient knows her body. She will often describe her condition with remarkable accuracy, in her own language, using her own framework. The clinician's task then becomes much smaller: to confirm what is correct, gently reframe what is not, and fill the specific gaps. This can be done in a fraction of the time of a full explanation. And the patient retains far more, because she is building on knowledge she already owns.

Shared Decision Making Under One Minute

The idea that shared decision making requires time is, in part, a myth. What it requires is a genuine orientation. A clinician who begins the consultation from a position of trust and equality can complete a shared decision in seconds. The patient says she does not want antibiotics. The doctor asks what she would prefer. She suggests waiting two days. The doctor honestly considers this. It is reasonable. They agree. She asks for a prescription to hold in case. He writes it. She leaves having made her own decision, with clinical guidance, in under a minute.

The enabling condition for this is not time. It is the clinician's genuine belief that the patient is an intelligent adult whose preferences are clinically relevant. And that belief, in the Sri Lankan context, does not need to be manufactured. It needs to be allowed. It is already consistent with manussakama. It only needs to be consciously connected to clinical practice.

Family as Clinical Infrastructure

In the Sri Lankan context the family is not a peripheral figure. Decisions are made collectively. The patient may defer entirely to a family member. A care plan that does not include the family is a care plan that may unravel the moment the patient leaves the hospital. The aunt who stops the insulin. The father who discontinues the antipsychotic after two weeks of apparent improvement. These are not ignorant acts in a vacuum. They are predictable consequences of a system that never brought the family into the conversation.

Treating the family as clinical infrastructure, not as an intrusion to be managed but as an essential part of the care team, is already consistent with Sri Lankan culture. It does not require a new framework. It requires only that it be named and deliberate rather than accidental.

Part Five: Implications for Medical Education

The conversation that produced this document began as an exploration of healthcare constraints. It arrived at medical education. This progression was not planned. It was inevitable. Because the constraints are not primarily resource constraints. They are thinking constraints. And thinking is formed in education.

The insight that emerged is both simple and radical: the books currently used to teach clinical medicine in Sri Lanka were written for a different context. Not a better context. A different one. The anatomy is the same. The pharmacology is the same. How to examine lungs is the same. But clinical methods, patient communication, ethics, clinical governance, public health, and record keeping, as taught through their current texts, carry assumptions that are wrong for the Sri Lankan clinical reality. They need not to be adapted. They need to be written.

What Needs to be Written Differently

Subject Area	What the current text assumes	What the Sri Lankan text must address
Clinical Methods	Quiet room, unhurried encounter, chaperone available, computer for documentation	When to do a targeted vs full examination; how to preserve dignity in a crowded space; how to communicate what you are doing to a frightened patient
Patient Communication	Individual autonomous patient; private consultation; educational materials available	Family in the room; collective decision making; patient as the starting point of education, not the endpoint
Ethics	Informed consent as a formal process; patient as autonomous agent; power differential manageable	Informed consent in a context where true autonomy is complicated by deep cultural hierarchy; how to protect the patient's voice
Clinical Governance	Electronic records; audit mechanisms; complaint pathways; quality frameworks	How to build accountability habits in the absence of structural enforcement; the forward-looking note; peer conversation as governance
Public Health	Population health with data systems; surveillance infrastructure; formal reporting	Community health through relational trust; informal networks as health infrastructure; the family as a public health unit
Record Keeping	Comprehensive structured documentation	Minimal meaningful notation; the forward-looking note; what must never be omitted even in two lines

How to Let Humanity Flow: The Central Pedagogical Task

Medical education globally spends considerable effort trying to teach empathy, patient-centred communication, and shared decision making. The results are mixed, because

these things are being taught as techniques. Students learn the technique. Patients feel the technique. Something is present but slightly hollow.

In the Sri Lankan context, this problem has a different shape. The empathy does not need to be taught. The manussakama is already there. What needs to be addressed is the systematic suppression of it, by shame, by the mythology of ideal conditions, by the colonial inheritance, by the misapplication of professionalism as emotional distance.

The central pedagogical task, then, is not to install something new. It is to stop dismantling something that is already there. Medical education in Sri Lanka needs to create space in which the student's natural humanity is named, celebrated, and protected from the forces that would otherwise slowly extinguish it.

This is a different kind of teaching. It requires educators who have done their own work on these questions. Who can sit with a student and say: the thing you feel when you walk into that ward, that pulling towards the person in the bed, that is not a weakness to be managed. That is your most important clinical instrument. Do not let anyone take it from you.

Dream Small, Act Local: An Educational Philosophy

The changes described above will not happen through curriculum reform committees or national education policy. They will happen through individual educators who begin to teach differently, in small ways, one conversation at a time. A ward round where the consultant asks the student not what the diagnosis is but what the patient told her. A bedside teaching moment where the family in the room is acknowledged rather than asked to step outside. A seminar where examination answers written partly in Sinhala or Tamil are received without shame.

None of these require institutional approval. None require a budget. None require anyone to be publicly wrong about anything. They only require the educator to have thought about these questions and to carry that thinking lightly into every interaction with a student.

That is the virus. And viruses do not ask permission.

Appendix: Two Letters

A Letter to the People

Dear Auntie, Uncle, Mama, Nenda,

I am writing this to you on my knees. Not because I am sad or begging. But because I have nothing to teach you. You already taught me everything I know.

You taught me manussakama. Not by telling me about it. You never gave me a lecture. You just let me grow up around you. You gave me food when you had barely enough for yourself. You let me sleep under your roof when the rain came. You pulled me out of trouble even when I was being stupid. You did not think about it. You just did it.

I am writing to tell you something you probably already know, but maybe you forgot because the world keeps telling you different things.

The world keeps telling you that you need to learn things. That you need to improve. That you need workshops and certificates and improvement. That your way is not enough. That you are missing something. That you should be more like them.

They are wrong.

Not because you are prefect and they are bad people. But because they are looking at the wrong level. They are looking at the top of the water. They are talking about the waves. They think the waves are the ocean.

But you are the ocean.

The thing you have — manussakama — is not something anyone can teach you. It is not something anyone can take from you. It is the ground you stand on. It is the thing that makes you give your last piece of bread to a stranger. It is the thing that makes you shoo the fly away while guarding the corpse of your greatest enemy slain by you.

Nobody put that in you. And nobody can take it out.

The foreigner comes with his lessons about respect. You listen. You nod. You honour him because he is a teacher and you know how to honour a teacher. And he thinks he is giving you something new. But you are giving him something he cannot even see. You are giving him the very thing that makes you listen to him in the first place. You are giving him your manussakama.

Do you see? Your treasure is not something that can be stolen. It is not something that can be bombed. It is not something that can be erased by workshops or shame or feeling inadequate.

The only way anyone could take it from you is if you yourself decide to throw it away. And even then, I am not sure it would leave you. I think it would just wait for you to remember.

So, this is my plea to you, my dear ones. Not a lesson. Just a plea.

Please do not feel small. Please do not feel ashamed. Please do not think you are missing something that others have.

You have the thing. The real thing. The thing that has no name in English. The thing that keeps this island breathing. The thing that has survived thousands of years of kings and colonizers and bombs and workshops.

You do not need to be proud. Pride is heavy. You can just be. Let manussakama flow. That is all you ever did. That is all you ever needed to do.

Everything else — the lessons, the certificates, the fancy words — that is extra. Put it on if you like. It might be tasty. Or leave it off. It does not matter. The cake is there. The manussakama is there.

And if what I am saying sounds like nonsense, if I am annoying you, if I am being a fool — please, slap me. I mean it. Because who am I to tell you anything? I am just someone who was lucky enough to be raised by you.

Thank you for teaching me what no school can teach. Thank you for being who you are.

With all my heart, a grateful child

A Letter to Doctors and Medical Students

Dear Doctor, Dear Student,

I am not writing to teach you anything.

I am writing because I think someone, somewhere, told you that you are not enough. That your clinic is not enough. That your system is not enough. That the way you were raised, the way you feel things, the way you instinctively reach toward a suffering human being, is not scientific enough, not structured enough to count as real medicine.

They were wrong.

You already have the most important thing. You had it before you opened your first anatomy textbook. You had it when you were a child and you felt something move inside you when you saw someone in pain. That thing has a name. Manussakama. And no examination, no curriculum, no postgraduate qualification gave it to you. And none of them can take it from you either.

The patient sitting in front of you today is not a case. She is a person. You already know this. You feel it. But somewhere between medical school and this moment, you may have learned to suppress that feeling. To keep it professional. To maintain distance. To be objective.

I am asking you to reconsider.

Not to be unprofessional. Not to lose your clinical rigour. But to stop treating your humanity as a liability. It is your most powerful clinical instrument. More powerful than any investigation. More powerful than any protocol. Because it is the thing that makes the patient in front of you trust you. Open up to you. Tell you the thing she almost did not mention. The thing that changes everything.

You are working in conditions that are genuinely difficult. The clinic is crowded. The resources are limited. The system does not always support you the way it should. And you were taught, perhaps without anyone realising it, to feel ashamed of this. To feel that what you do here is a lesser version of real medicine practiced somewhere else under ideal conditions.

There are no ideal conditions. There is only this patient. This moment. This conversation. And you.

You do not need an electronic record system to remember that the man in front of you looks more frightened than his complaint suggests. You do not need a formal risk assessment framework to notice that something is not right. You already notice. You have always noticed. That is manussakama working through your clinical eyes.

Trust it.

When you ask the patient what she thinks is happening, you are not being lazy. You are being intelligent. She knows things about her body that you cannot find in any textbook. And she will tell you, if you ask, and if she feels that you genuinely want to know.

You can do this in one minute. With a crowded waiting room outside. With no computer. With no allied health team behind you. Because manussakama does not require time or resources. It requires only that you stop blocking it.

Dream small. Act local. Change one conversation today. Then another tomorrow. Do not wait for the system to change first. Do not wait for ideal conditions. Do not wait for someone to give you permission to be fully human in your clinical work.

You already have permission. You were born with it.

The patient in front of you does not need the best doctor in the world. She needs you. Fully present. Genuinely caring. Honestly humble. That is everything. That is medicine.

And if you forget all of this by tomorrow morning, which is entirely possible in a busy clinic, just remember one thing.

Manussakama. It is already there. Just let it flow.

With deep respect for everything you carry into that clinic every single day,

A fellow traveller

A Final Note

This document is not finished. It was never meant to be finished. It is a beginning of a conversation, and conversations do not finish. They find new people, mutate in productive ways, and continue in forms their originators could not have predicted.

If you are reading this and something in it rang true, the only thing being asked of you is this: carry it into one conversation. With one colleague. With one student. At the bedside of one patient. Do not announce it. Do not present it at grand rounds. Do not send it to a committee.

Just let it flow.

> *Those who come after will do the rest. Even after our deaths. They have to. So they will.*

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Manussakama