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ABSTRACT

A research project was conducted to determine how and what clown-doctors know on entry to the profession and how and what they learn both formally and informally in a hospital environment; the linkages between informal and formal learning in clown-doctor training and practice in Canada; and "best practices." Information was gathered through personal research (continuing), interviews with clowns and training personnel in Winnipeg, Vancouver, and Toronto; a conference in Europe; roundtable discussions; and informal discussions by telephone and e-mail. The research found that the current clown programs in Canadian hospitals, dating to 1986, take two major approaches: (1) clowns who wear circus-style costumes and make-up work as part of the child life program at a single hospital, work alone, are non-verbal, bring props and toys, do not use music, and play within a "small" and quiet way; and (2) clowns who usually wear a white coat, red nose, and minimal make-up, have unique personalities and names, work in pairs, are not hospital employees or work in several hospitals, and use sound, language, and music. The study found that all 10 clowns currently working in Canada have wide educational backgrounds and have had both formal and informal training that has helped prepare them for their work as clown-doctors. Most of their additional professional development occurs through informal interaction with other clowns, with healthcare staff, and with patients and family members. The study concluded that while all the Canadian clowns are professional and useful in their fields, there is an urgent need to examine, design, and develop appropriate professional development and inservice training models and modules for clown-doctors. (KC)

Knowing Laughter: What Do Clown-Doctors Know and How Do They Learn To Do What They Do? NALL Working Paper.

NALL Working Paper #43-2001

Bernie Warren

KNOWING LAUGHTER

What do clown-doctors[1] know and how do they learn to do what they do?

Bernie Warren

NALL

EVERYBODY HAS TO START SOMEWHERE

The investigation supported by NALL was undertaken against a backdrop of previous inquiry into the work of European and American practitioners which suggested that while clown-doctors are not healers or teachers they nevertheless appear to play a significant part in the process of treatment and education that takes place in hospitals. However, clown-doctors seem to epitomise Michael Polanyi's comment: "We know more than we can say" (PERSONAL KNOWLEDGE (1962)).

My NALL supported research sought to:

- discover how & what clown-doctors know on entry to the profession and how & what they learn both formally and informally in a hospital environment
- examine the linkages between informal and formal learning in clown-doctor training and practice in Canada in an attempt to begin to identify "best practices"
- apply any insights gained to new training programs,[2]
- consider how to develop multi-media training packages that may be delivered, at least in part, at a distance.

It should be noted that the research undertaken was part of a bigger picture of continuing worldwide research into the role of clowns in Health Promotion and Health Care and while the work that NALL supported focused solely on the work of Canadian clowns several other initiatives continued to look at European and American practice. Consequently, within this document occasional reference is made to information gathered from these other sources, especially where it influenced or reflects upon the work undertaken in Canada. As a final preface, rather than keep my commentary and observations to the end of the document, I have added 'editorial' comments which reflect my analysis of the information gathered at the point that it is presented. It should be stressed that this is simply one point of view and to some extent reflects my biases about the work!

BEST LAID PLANS ... the shortest distance between two points is not always a straight line...

My original plan was to conduct interviews with clown-doctors from around the world at a symposium in Strasbourg[3] and to conduct a brief study of three clowns from Le Rire Medecin in Paris and three clowns at Sick Children's Hospital in Toronto, so as to compare different approaches to the work. However, NALL's rules did not permit foreign travel and so this plan was changed. I knew I had to keep my research plan small, self contained and relatively simple so as to stay within my budget allocation and to keep to NALL's strict timelines.

In the proposal that was approved, I intended to focus my efforts on the therapeutic clown program at Hospital for Sick Children in Toronto and on PLAY IT AGAIN, a conference in Winnipeg where all Canadian practitioners were to be present. My plan was to conduct individual interviews and shadow the work of the three clowns in Toronto and then to conduct individual interviews with clown-doctors in Winnipeg. All interviews were to be taped, transcribed and analysed.

I spent the first stage of the research arranging a time to visit the Toronto program. We agreed on a date in February which was mutually acceptable. At the same time I made arrangements to participate in the Winnipeg conference. I was fairly happy with these arrangements until, immediately prior to my visit to Toronto I attended the Symposium in Strasbourg(4).While at the Symposium I conducted interviews with five clown-doctors (from France, Germany, Holland, Italy, Sweden respectively) three of whom had started work with Clown Care Unit in New York prior to starting their own programs in Europe. At the Strasbourg meeting I discussed the Canadian research plan. All the European clowns insisted that I really needed to visit each program and that simply holding interviews in Winnipeg was not adequate!

The European clowns' wisdom became obvious when I visited the Toronto program. As soon as I began to shadow the three Toronto clowns I realised how different each was one from the other in terms of their training, experience and ways of interacting in a hospital setting. This first impression was amplified when I started to ask about their own life-histories and the work in general. Each talked of how different their program is from the ones in Winnipeg and Vancouver. As a result of these insights I changed my travel plans and arranged to visit the Therapeutic Clown program at Children's Hospital in Winnipeg prior to attending the PLAY IT AGAIN conference. My view at this point was that visiting two of the three established programs would give me a good picture of Canadian practice.

I should at this point make a qualifying statement. My original research plans were based on nearly ten years of research into laughter and healing in general and nearly three years of intensive investigation into and discussions with clowns working in hospitals. However, once again the Winnipeg conference illuminated the flaws in my planning. From discussions, meetings and recorded interviews it became apparent that to get a real picture of Canadian practice I had to visit the third major clown-doctor program in Vancouver. However, by this time my budget had all but been used up, it was at this point that I requested and was granted additional funding to make the trip to Vancouver. Unfortunately, for several reasons (not all financial) my trip to Vancouver couldn't happen until late July, much later than I would have liked and after initial training for the FOOLS FOR HEALTH program had finished. The final piece of information is that I decided to hold off this report until the very last minute so that I can include information gained from the work of the clowns working in the new program in Windsor.

TRIPPING OVER MY OWN FEET... collecting and making sense of the data

Information was gathered about the programs in Winnipeg, Vancouver & Toronto via interviews and round table discussions. All information gathered from these sessions was taped and transcribed. In addition to the taped sessions. I visited each program and observed all the clowns at work. While at each of the hospitals I also met and talked with supervisors and co-workers. I took extensive notes during these hospital visits . I also kept notes on informal discussions held with the clowns while visiting their hospital and by phone and e-mail.

In addition to the programs in Winnipeg, Vancouver & Toronto I collected information about the program in Montreal(5) through a taped interview with Olivier-Hugues, the round table discussion and notes taken from informal discussions by phone and e-mail. In addition Olivier-Hugues was a participant(as was Joan Barrington) in the 2 week training provided for the Windsor clown-doctors(6) . Here again many interesting comments were either noted or recorded.

During the life of the NALL research the FOOLS FOR HEALTH project began in Windsor. While the focus of the research for this project is different to that being conducted for NALL much of the baseline information was relevant. Prior to starting the project information was gathered about the preparation and training of the performers PRIOR to joining the project. In addition information is being gathered throughout the project concerning how and what the clowns learn on the job. This information is still in the process of being collected . Analysis will not begin until the end of August and so will NOT be available until after this report has been submitted.

All information gathered by tape was transcribed and colour coded first using keywords and then

category analysis. The keywords and categories were developed from work conducted earlier with American and European clowns . Salient information was charted using sub-headings. Information relevant to more than one category was listed in each. Patterns and contradictions were examined and noted. Cross reference was made to notes taken outside of the taped interviews. Where appropriate inconsistencies and questions were checked with the individual concerned. Every effort was made to ensure the accuracy of information. However it is not inconceivable that errors may have been made.

A final point , each program suggested that a single visit was not sufficient to get a true picture of the day to day activities and learning of the clowns. The work currently being undertaken in the FOOLS FOR HEALTH project bears this out. So what follows should be considered a 'snapshot' , a brief summary of the knowledge and praxis of Canadian clowns. However it must be understood that this a merely a single picture and while it may be a 'good enough' picture of the work, it is nevertheless a limited view.

A BRIEF WORD FROM OUR SPONSORS ...some of the differences between Canadian programs

Clowns have worked in hospital settings at least since the time of Hippocrates, whose own hospital maintained constant troupes of players and clowns in the quadrangle. While there were several precursors from the 1950's onwards, professional clown-doctoring really began in 1986. At that time Michael Christensen (Dr. Stubbs), along with Jeff Gordon ('disorderly Gordoon'), began a clown-doctor program in New York. This work led to the formation of the BIG APPLE CIRCUS CLOWN CARE UNIT (CCU). Simultaneously, Karen Ridd ('Robo') a solo performer, who was also a child life specialist initiated an experimental project in Winnipeg Children's Hospital in Canada. This became Winnipeg's Therapeutic Clown program.(7) Both programs are alive and well. They have expanded and acted as catalysts for many programs around the world and represent two major approaches to the work.(8)

Both approaches work with healthcare professionals to improve the Quality of Life and speed the healing of the patients they serve. However there are notable differences between the two approaches .

Programs influenced by ROB employ clowns who usually :

- wear trademark bright circus style clothes and make up
- work as part of the child life program of a single hospital
- work alone on the wards
- carry a lot of props and toys with them
- are non-verbal often silent
- communicate via gestures & simple sounds eg. squeaks, sighs etc
- do not use music or play instruments
- focus on the child/patient
- are rarely 'theatrical' or 'disruptive'
- play within a contained range in a 'small' & relatively quiet way

Programs influenced by CCU employ clowns who usually:

- wear a white coat, a red nose and minimal make up
- are called DR. eg Dr. L'air de Rien, Dr. Fifi, Dr. Opera, etc
- have an unique personality & name often identified by a distinctive trademark [eg. yellow taffeta tutu (Dr. Twinkle-Toes), Giraffe ears (Dr. Giraffe) ...] connected to that name
- are autonomous ie NOT hospital employees and/or work in several hospitals
- work in pairs (dubbed a 'clown marriage') on the wards carry minimal props/toys but rather work by improvising with what is in the room (known as 'empty pocket clowning')
- are verbal and use language
- communicate using a wide scope of gesture sound and language ranging from silence and simple gesture through to loud and gregarious dialogue as the situation demands
- use music and song extensively

- focus as much on the family members & healthcare workers as the patient
- are often 'theatrical' and deliberately (but appropriately) 'disruptive'
- play in a wide range-from playing of quiet 'meditative' music or sitting quietly at a bedside, through to loud, boisterous and anarchic productions of Shakespeare's plays or Tchaikovsky ballets that involve anyone (patients, family, nurses, Drs., etc.) in close proximity at the time

It should also be noted that Clown Care Unit's approach to working in hospitals, while developed in North America, is strongly influenced by what may be loosely referred to as the 'European School' of clowning.

Currently clowns are employed in hundreds of hospitals and healthcare settings in at least a dozen different countries around the world. (including Canada, Britain, France, Brazil, Austria, Germany, Italy, Switzerland, Spain and The States) . In Canada , at the time of writing , there are programs employing clowns in Hospitals in Vancouver, Toronto, Winnipeg and most recently in Windsor. In addition a pilot project recently finished in Montreal and a new program is expected to begin before the end of 2001.

The programs in Winnipeg and Toronto are clearly influenced by ROB's work. Both are directly 'administered' through the child-life departments of the hospitals and David is employed as a child-life specialist ('Hubert' , his clown is only part of his job description). The program in Windsor is strongly influenced(as was the one in Montreal) by the work of Le Rire Medecin in Paris, themselves 'descendants' of CCU. The Windsor and Montreal program both operate 'independent' of the Hospital hierarchy and administration.

The program in Vancouver may be considered a 'hybrid' as it is influenced by both major approaches to the work . Here there is a solitary clown who does not wear circus clothes or make up, is referred to as Doc or Dr., is verbal and plays music but also carries lots of props &toys and works as part of the child life program of a single hospital.

Having given a thumbnail sketch and some background information about the program I will now move to a discussion of the clowns who work in them.

LEARNING TO BE STUPID...what clown-doctors know PRIOR to working in hospitals

At the end of the day I interviewed ten individuals and shadowed nine of them in their work as clowns in Canadian hospitals(9). Four of these individuals had been working in hospital settings for more than three years. Six had less than one year's experience and of these, three had no experience prior to July 2001.

The four experienced Individuals have widely different backgrounds and work experiences. Camilla and Joan work in Toronto, David in Winnipeg and Paul in Vancouver. David has an undergraduate degree in English and Drama. He also has a teaching degree and for a short while taught drama and theatre. Paul began a degree in Technical Theatre but left to study mime in Paris with Marcel Marceau and Etienne Decroux, two of the top mime teachers in the world at the time. In addition both David and Paul are highly skilled musicians.

Prior to their work in hospitals both David and Paul often worked as professional clowns. Both have extensive training in clown 'skills', gained mainly from workshops but also from working with other clowns. Of particular note are the following pieces of information. In the early 1970's Paul worked in the streets of Europe as a clown/ mime with Le Palais des Merveilles a company whose co-founder was Caroline Simonds, the director and founder of Le Rire Medecin. David worked with several clown companies in Winnipeg including one called Lunacy where he worked with Karen Ridd ('ROB') the founder of the Therapeutic Clown Program in Winnipeg. As may be intimated from their backgrounds, their connections to the world of clown-doctors started early in their careers.

Camilla trained as a Montessori teacher and has a Master's degree in Library Science. Currently she is

pursuing graduate studies at OISE in Holistic Education. Prior to her hospital work she worked as a teacher and children's librarian and is a published author and a well known storyteller and workshop leader. She began her clown work fairly recently, initially developing her clown through workshops with Karen Ridd and with Avner the Eccentric (Avner Eisenberg), a well known and well respected clown 'master'.

Joan studied Arts Management at Humber College. She was influenced by her aunt who was both an actress and a teacher of drama & speech for children. In addition she took classes in movement and drama with Leah Posland and Maggie Bassett . Prior to working in hospitals she did some volunteer and party clown work. She also plays a little flute. She developed her clown through workshops and a 'mentoring' process with Karen Ridd.

The six less experienced clown-doctors are younger and generally have more formal academic training in drama and theatre skills. Lucia works in Toronto, Olivier-Hugues in Montreal while Melissa, Judy, Nick and Crystal are currently working in Windsor.

Lucia is the newest addition to the Toronto program. She has a Masters degree in Comparative Literature and an extensive background in various styles of theatre including Commedia D'ell Arte (which she studied in Italy with one of the top modern teachers) and clown & mask work which she studied with Richard Pochenko, who was, until his recent death, probably the top clown 'master' in Canada. Olivier-Hugues studied modern dance and theatre anthropology at UQAM in Montreal. He later studied physical theatre in Winnipeg with Richard Fowler's company PRIMUS (one of the top training grounds for physical theatre currently available in the world). He has studied with a number of clown teacher's including Don Reider,of KLOWNIATA in Montreal.

The Windsor clowns have many common threads to their training. Crystal, Melissa and Judy have all completed, and Nick is in his final year of, an undergraduate degree in drama and education. In addition, Judy, Melissa and Crystal are trained teachers. Prior to her clown work Crystal was the elementary school music specialist for her school board and Melissa taught English for The National Circus school in Montreal.

Judy, Nick and Crystal had all studied clowning as part of their academic training. Melissa studied Clown & Mask with Sue Morrison and had previously worked for almost a year as a clown-doctor with The Drama Practice in Scotland. Judy originally studied to be a professional actress both at The School of Dramatic Art at the University of Windsor and at The Actors Studio in New York. Both Nick and Crystal are trained and highly skilled multi-instrumentalists, Judy is an accomplished Accordion player and all four are good singers. All four took a 3 week intensive training course supervised by myself and Caroline Simonds, prior to being let loose to work on their own as clown-doctors in the hospital.

In addition to all of their other skills most of the clowns are able to communicate in more than one language. Olivier-Hugues, Paul, Melissa and Lucia are all functionally bilingual in both official languages. Judy and Lucia speak Italian, Joan speaks German, Melissa speaks Spanish, David is can communicate in a first nations language (or two?) and Judy, Nick, Crystal and Melissa are an communicate in ASL. This ability to communicate in more than one language is sometimes a great asset as wards in urban hospitals are often multi-cultural and multi-lingual environments.

FOOLS AND THEIR MIRRORS ... how DO clown-doctors learn in hospitals

All ten clowns currently working in Canadian hospitals have had both formal and informal training that has helped prepare them for their work as a clown-doctor. However, once hired for a hospital program each clown has to learn how to survive on a day to day basis.

The preparatory training of new clowns ideally involves both formal and informal elements that address clown skills and their 'appropriate' use in a hospital and an orientation to the hospital in general and to healthcare procedures of the specific ward on which they will work. To provide some context, Le Rire Medecin and Clown Care Unit make all new clowns undergo a rigorous training program before being

set free in a hospital. They have the financial resources and personnel available to design, develop and deliver what they believe to be the appropriate training. Unfortunately in Canada the mix of preparatory training is more often determined by budgets and critical mass than by philosophy or pedagogy.

Until very recently Canadian programs involved only ONE clown. To give a sense of the scale of the problem, Le Rire Medecin employs 30+ clowns and the Clown Care Unit 90+ clowns . Currently, of the well established programs, Toronto is still the only program to involve more than one clown. It is difficult to justify a budget line item to provide site specific training for even three clowns (for one it is almost impossible). So training of new Canadian clowns has been an uphill battle(10).

That being said the well-established programs do have access to hospital staff to give standard talks about hospital orientation , hygiene and other operating procedures. Sometimes these are tailored to the needs of the program . They also have the opportunity to shadow and observe experienced clowns at work. The element that is missing is that they don't have the critical mass to develop site specific workshops on clowning in Hospital. What this often means is that the new clown has to take 'off the rack' workshops that may not meet the needs of the Hospital environment. Toronto is well aware of the problems and are looking at ways to develop better preparatory and in-service training modules.

Another problem is keeping the work new and alive. To continually grow on the job and to develop as a performer, a clown-doctor and as a person. There need to be opportunities for both informal and in-service learning to occur. The best example of this is Le Rire Medecin who run regular in-service training sessions for the company. They have a consultant clown master who runs frequent day long clown skills workshops. In addition, about once every 3-5 weeks, Medical personnel give seminars on specific medical topics relevant to the company's work . Finally once a month the company meets en masse to discuss an aspect of the work. To my knowledge no other company has such an extensive and integrated approach to lifelong learning and none of these elements are in place anywhere in Canada.

Again the sheer size of Canadian operations make it difficult to run these sorts of in-service opportunities on a regular basis. The clowns do have opportunities to attend conferences on both 'general' healthcare issues and on clowning or theatre skills, and in some cases the expenses are paid by the hospital. However, for the most part, clowns continued development is from informal learning mainly from the following interactions:

- with other clowns
- with healthcare staff
- with patients and/or family members

I'M WITH STUPID - Clowns learning from clowns

Globally, clown to clown learning occurs in three ways: formal group meetings; informal talks and discussions both inside & outside the work place,; and working with a partner on the wards. My research suggests that most clowns working in hospitals feel that the most important of these ways of informal learning is through working with a partner on the wards in direct interactions with any combination of staff, patients and family members.

There are many good reasons why in a hospital setting it is advantageous for clowns to work in pairs. Some of the reasons relate to performance. A solitary clown-doctor, no matter how skilled they may be, is limited. Without a proficient, professionally trained partner they are forced to either put on a show, to entertain, or 'place 'pressure' on the patient to be part of the performance. For when a solitary clown performs there is no one to lend another point of view; initiate a new piece of business; create improvisational conflict; help reset the volume if the clown is too 'loud' or too 'soft'; or at the end of the day, to discuss the day's events.

Often another professional clown is the only person who can let his partner know, within the moment of improvised chaos, when they have gone 'Over The Top' and more importantly know ways to help

retrieve the situation and turn what may have been a potentially traumatic moment into a cathartic healing one. More than this, 2 clowns can create a richness in the work where the sum of the whole is greater than the sum of the parts. Most importantly, this shared experience often enables clowns to develop coping strategies and problem solving skills simply from watching another skilled professional at work.

Again the scale of Canadian programs creates problems. Simply put, unlike European and American clown-doctor programs, the opportunity for a clown-doctor to learn from another clown are very few and far between for (except for Montreal and Windsor) most Canadians work alone. In Winnipeg and Vancouver there are NO other clowns and thus no opportunity for this kind of on the job learning except when a brother or sister clown comes to visit and play.

Even in Toronto the opportunities for this sort of learning are limited to infrequent meetings among the three clowns, although they are discussing ways that they may occasionally partner one another on the wards. So in Canada the bulk of (for Paul and David the ONLY) clown to clown learning, occurs in unscheduled, infrequent and informal meetings with other clowns and via e-mail.

STOP ME IF YOU'VE HEARD THIS ONE ... learning from healthcare professionals

Globally, colleagues from other healthcare professions are probably the next greatest source of clowns' informal learning. The information gained may also be the most significant . Many anecdotal stories bear witness to how clowns have learned to deal with weighty topics such as the death of a child to more lighthearted advice concerning how to cope with hospital smells, especially those of faeces and urine. Information is gained from colleagues in different ways, some more formal than others.

All reputable clown-doctor programs have some form of daily check-in before visiting patients. In most Canadian programs this involves meeting with a member of the child-life team. In Winnipeg , where David Langdon is employed as a child-life specialist, on clown days he simply refers to a cardex system used by all child life specialists. In Windsor the clowns meet with a charge nurse before changing into their clown costume. These meetings provide clowns with information about the patients on a day to day basis and to make requests about who needs a visit and perhaps what sort of intervention is being asked for from the clown. In some programs, such as Windsor, the check-in also provides a structured time for healthcare staff feedback about the clown's work, behaviour and noise levels. This is important because sometimes what may be beneficial for a patient and their family may seem 'disruptive' to a healthcare team member who is trying to do their job.

In addition to a daily check-in, some programs participate in 'rounds'. In Toronto the clowns go 'occasionally' to rounds both to observe and share their observations. David Langdon, in his child-life role, is a de facto member of rounds. In Windsor, the clowns attend all team rounds and gain, and share, information about patients' weekly progress from the perspective of all doctors, nurses, therapists, and other healthcare professionals who work with them. However as Lucia points out 'I'll get all this information about a patient' ... 'when I'm in clown I completely forget what I was told'.

It must be pointed out that Clowns often know salient information not cerebrally but 'in their bones'. As I have been seeing on a regular basis choices made for a patient in clown are directly related to the patient's treatment program discussed in rounds or even on the fly in the hallway with a nurse.. However, clowns when complimented on their planning look blank and make it clear that any connection was subconscious. However, this 'mindlessness' (mind of a child) rather than being seen as a weakness is the very reason why the clowns are successful.

In addition to these structured information gathering and sharing sessions, there are also many ad hoc meetings on the wards between clowns and healthcare staff where information is shared. This may range from a brief notification concerning a patient's health, a request to leave a patient alone through to a need for a clown to visit a particular room. This sharing on the fly is often essential. It is important to develop a ritual or routine by which this information sharing may occur. This can range from a brief word whispered in a clown's ear as they pass to a request for a moment alone.

For clowns who wear red noses it is a simple procedure to engage in a conversation with Healthcare staff (or parents) as themselves NOT their clown as they can go into 'noses down'[11] mode at anytime . However for clowns who are silent, and/or who use a lot of make-up to create their clown persona, there are some complications. It is very hard for the person to appear quickly from behind the clown to engage in a 'serious' conversation. However, the problem is not insurmountable and all the experienced clowns who are silent/wear make-up have developed a code for such interactions as they arise.

In addition to finding ways of sharing information on the fly it is most important that when necessary the healthcare staff have a way to 'shoo away' clowns, a simple signal that lets the clown(s) know they are not wanted. This helps prevent misunderstandings eg where a family member or a patient invite the clowns in to the room to play at a time when a healthcare worker is trying to carry out a delicate procedure or begin a difficult discussion.

Finally, and perhaps most importantly, significant learning occurs when clowns go 'inclownito'[12] to join healthcare staff for lunch or coffee . Once the clowns have been accepted as members of the 'healthcare family' it is important to build in times to simply 'hang out' with colleagues and discuss stuff NOT related to the patients or the hospital.

OUT OF THE MOUTHS OF BABES AND AUNTIES ...it's all in the family

The other major area where clowns learn is in their interactions with patients and with patients' families. It is a double mirror because more than any other source patients and their families illuminate what is 'really, real in the work. Anecdotes abound about how this or that incident helped to shape the clowns practice.

All professional clowns, especially those who work in pairs, engage in 'rehearsals' where they prepare lazzi (comedic, predominantly physical business), songs and other bits of 'schtick' to take onto the ward. However at least as many new activities are generated by the clowns' interactions with people on the wards than by 'rehearsal'. A simple example of a new idea coming from a patient came when I was visiting Paul Hooson in Vancouver . Dr. Willikers was playing with a young girl who has cancer . Using a standard lazzi of a 'squeakotomy', Paul was placing and removing a squeak from parts of the girl's body . However, this young girl had other ideas as to how to use the squeaker! She used it like a television remote allowing the clown to speak or be mute, at her discretion. After leaving the room Paul said I'd never have thought of that but I'm sure she will want to play this game again. Also the way a patient or a family member interacts with a clown can illuminate their practice in other ways. Camilla tells a story about working with an East Indian family who called her 'auntie' and how that made her think about how to adapt her clown to the patient's own culture.

Often information is freely given to a clown that either puts the patient's behaviour in a new light or gives ideas about how to approach the patient or a family member. Many clowns talk about how sometimes the patient will share information that is NOT contained anywhere in patient records! For example clowns in Windsor working with a patient who had had a tracheotomy and was being taught how to speak again found out that she loved to sing and had a large repertoire of songs. Or they will find ways of getting the patients to be compliant, to cooperate with their treatment that no one else can do. The clown can then share this with other members of the healthcare team. This has added benefits as it increases the interactions and informal learning with the healthcare team.

The key thing in all the above is that the clown has to learn to be fully attentive. The French clowns refer to this as 'listening with all antennas up'. For to be successful and to continue to grow a clown-doctor must be a creative detective. They have to learn to not go in with a set agenda but must be ready willing and able to listen to any and every clue they are given. They may not always be able to make sense or make use of the information immediately. It may take some time and perhaps discussion with other members of the healthcare team to process how best to incorporate this new knowledge into their work. However, the point stands that if you have switched off the receivers you won't hear the incoming message!

A WORD WHISPERED IN THE EAR OF ONE PERSON... disseminating information

The information gathered from this research, especially that on "best practices", has already influenced the training of clown-doctors on the FOOLS FOR HEALTH project. It will also be shared with all Canadian clowns. Olivier-Hughes is already making use of this information in Montreal and I feel sure that it will influence other clown-doctor programs as they develop in Canada. To what extent it will influence established programs in Vancouver, Winnipeg and Toronto, ... well, It isn't always easy to teach an old dog new tricks. It will depend on the extent that they are able to listen to and see the suggestions as beneficial to their work.

Information gained from this research will be disseminated through conference presentations, articles and books. In addition two chapters based in large part on this research are in the process of being completed :

> "THE LONG AND WINDING ROAD TO 'FOOLS FOR HEALTH': introducing clown-doctors to Windsor Hospitals" to appear in CREATING A THEATRE IN YOUR CLASSROOM AND COMMUNITY (Ed: Bernie Warren, pub: Captus University Publications) Estimated publication date: Nov. 2001
>
> "THE FOOL AND HIS MIRROR - how clowns learn and teach in hospitals" to appear in HOW THEATRE TEACHES. (Eds.: David Booth & Kathleen Gallagher pub: The University of Toronto Press) Estimated publication date : Dec. 2001
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> A paper "FOOLS FOR HEALTH: Integrating East and West, with humour" will be presented at the ART AND SCIENCE OF HEALING II a medical conference to be held in Vancouver in October 2001.
>
> IF YOU WANT TO KNOW WHERE YOU'RE GOING, LOOK BACK TO SEE WHERE YOU'VE COME FROM ....conclusions

Throughout this report I have engaged in a commentary on Canadian practice.

Simple things stand out from this brief research especially when held against the backdrop of the American and European research. Here are what I feel to be some of the most important points.

One of the big questions from all my research is whether there in a generic sense such a thing as "best practice". It is clear that every successful program I have seen around the world, even those operated by the same company, are to greater or lesser extent tailored to the needs of the context in which they operate ie: to a large extent best practice IS site specific.

Irrespective of their style ALL Canadian clowns are extremely professional in their interactions with healthcare staff, patients and their families. In addition there is very little back-biting or animosity amongst the programs and there is a general willingness to share and listen to information.

Most leaders of the well established Canadian programs are happy with the way their program runs. There is absolutely NO doubt in my mind that all the Canadian programs do what they do very well and are well received by their hospitals and by the human beings who they 'serve'. From this perspective all the Canadian programs are all "good enough". However, based on my global research, the question is not, "Is what Canadian clowns do good enough?" but rather, "What can they do to improve their practice and their program(s)?"

Canadian clowns are fiercely loyal and proud of their connections to ROB. They often contend that what they do is different to the work carried out by CCU in America and LRM in Paris. However, there are always things to be learned from expert practice wherever it may be found. There is no doubt that there are things that may be learned from the "best practices" of the European and American programs.

HERE ARE SOME AREAS THAT I HAVE IDENTIFIED:

Many of the clowns working in Canadian hospitals are at very least adequate musicians and/or singers , some are highly skilled in these areas. Given the documented success of the use of music in hospital-based clown programs (13) this seems an area that could easily be capitalised upon with a minimum of effort or expense.

A more contentious issue is the one of working with a partner. It is clear that in Canadian practice ROB's 'mother imprint' is very strong! However many Canadian clowns recognise the value of working in a 'Clown Marriage' and often enjoy when a colleague comes to clown with them in their hospital. There are simple ways that working in pairs or larger groups may be accomplished without changing the core of their practice or their basic approach. For example, In Windsor clown-doctors work in pairs but from time to time all 4 clowns work together in the lobby and the foyer. Also once a week they give a short "clown recital", an interactive performance that brings the patients out of their rooms and together in a central location for about 30 minutes.

All clowns should have the patients' well-being and quality of life as their primary focus . Canadian clowns can not be faulted in this area . Their work is often highly patient intensive. When this happens, in a sense their work could be described as being closer to play therapy than theatre.

The downside of what Canadians excel at is that (with the exception of David Langdon who is a child-life therapist) none of the Canadian clowns are trained to work as therapists! However, most clowns agree that the strength of their work results from the fact that they are NOT therapists.

This sets up a conundrum. For other than their costume and make-up or red nose they have no defence against transference or counter-transference and NO training to deal with 'deeper' personal issues. A Clown's strength , their defence, is in simply being a clown and doing foolish things. By being a clown, the lowest of the low in the hospital hierarchy, patients and family feel safe in telling and doing things they wouldn't do with, or say to, any other professional. However if Canadian clowns continue to work in this extremely focused play centred way, it is probably highly advisable that they gain more training in therapy and therapeutic methods.

While there is no formal or standardised training currently available (and some may argue there should NEVER be) for the most part Canadian clown-doctors are well prepared for the work. However, as more programs develop in Canadian hospitals a closer look may need to be made in to what skills sets and competencies are necessary to do the work.

The opportunities for professional development are extremely limited for clowns working in Canadian hospitals. The availability of in-service training in clown-doctor skills are all but not existent. This would not be such a problem if the opportunity for informal collegial exchange was greater and if it were seen as an essential part of the work, as it is with CCU and LRM. BUT clowns in Vancouver and Winnipeg work alone and in Toronto, even though there are three of them, as yet the opportunities for collegial exchange are very limited and appear to be given a relatively low priority. Even with the injection of new blood, with the addition of extra clowns, there must be a means of sharing ideas and information not just with hospital colleagues. It is essential to share and even challenge the work with other professional clown-doctors. The other alternative is for the work to remain static and stagnate!

There is an urgent need to examine, design and develop appropriate professional development and in-service training models and modules for clown-doctors working in Canada.

ENDNOTES

1. The term "clown-doctor" will be used throughout this proposal to describe a clown who works in a therapeutic
program within a hospital.

A clown-doctor is a specially trained professional artist who works in a hospital . Clown-doctors use interpersonal and
communication skills coupled with the skills improvisational techniques of Clowning [in such skill areas as comic acting, lazzi (pratfalls comic business), music, movement/dance, poetry, juggling, magic] to help PROMOTE wellness and IMPROVE physical and mental health and quality of life of patients, their families and the healthcare staff who interact with them.
Some would argue that this term clown-doctor is inappropriate as a generic term and that it should only be applied to clowns who follow the model developed by CLOWN CARE UNIT. Other frequently used names include "hospital clown", "therapeutic clown", "clini-clown". It should be noted here that clowns working in Canadian programs usually refer to themselves as therapeutic clowns.

2. Much of the information gained from this research is already being implemented , especially in the Windsor FOOLS FOR HEALTH program, a two month pilot/demonstration project, grounded by research into international praxis, that employs 4 clown-doctors on the in-patient rehabilitation unit at Windsor Regional Hospital. This initiative is being supported by grants from The University of Windsors Research Board & The Windsor Regional Hospital Foundation .

The project is first phase of a proposed larger community based program being developed by The Hospice of Windsor and The University of Windsor in association with local hospitals and community health groups in Windsor and Essex County.

3. The First European Symposium on the Arts in Hospitals and Healthcare.

4. This visit and research was supported by a n Academic Travel Grant from The University of Windsor and by the French Ministry of Culture & ADCEP(the Symposium organising committee)

5. The only program I did not visit although I did get a chance to watch Olivier-Hugues at work when he came to Windsor.

6. The two weeks of training preceded the Windsor Clowns working in the Hospital. It was conducted by myself , Caroline Simonds and Merrill Flewelling . Joan and Olivier elected to take this training to improve their own skills. However, they were also able to share their own experiences and thus contribute to both their own and others learning process.

7. Interestingly enough neither knew about the others work and to this day they have never it is my understanding they have never met one another!

8. There are other models of practice for clowns working in hospitals. For example, Some clowns are also clergyclowns for Christ, others are simply entertainers either as volunteers or on a semi-professional basis. while still others are doctors who use humour as part of their medical practice.

However for the purposes of this document I have limited my discussion to two major and diametrically different approaches , which may be considered at opposite ends of a continuum of professional clown work.

9. Names of Canadian Clowns , clown names in ( ):
Camilla Gryski*(POSIE), Lucia (NULLA) and Joan Barrington* (BUNKY) - Toronto ;
David Langdon* (HUBERT) - Winnipeg ;
Paul Hooson* (DOC WILLIKERS) - Vancouver ;
Crystal Brennan(Dr. OPERA), Nick Morrison(Dr. TWINKLE-TOES),
Judy Spadafora(Dr. POOPS) and Melissa Holland(Dr. FIFI) - Windsor;
Olivier-Hugues**(Dr. LAIR DE RIEN) -Montreal
* more than 5 years experience
**only person I did not see at work in his own program

10. This statement doesn't really apply to the Vancouver and Winnipeg programs as both seem

philosophically resistant to the notion of adding clowns to their program, even though at first glance it would appear that there is work and money available to support this. While they do make many good arguments about why they want to keep the program small, I am not alone in the belief that this is limiting the development of the programs. On the other hand the Toronto program is looking to slowly expand its personnel and they are looking to add one new clown later this year.

11. Clowns who wear a red nose can simply step out of character by lowering the nose which is attached by elastic behind the neck.

12. Inclownito , is a term used to describe when, as part of their work, a clown communicates or interacts as themself . with hospital personnel and occasionally patients family.

13. This appears to be true even where the hospital has music therapists or a visiting musicians program.

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