I spent a year at the Lecoq School in 1993–94. During that time, a close relative of mine was in hospital, and I hurried home at the end of the first year to be with her. Spending time in a hospital was a harrowing experience, perhaps made more frustrating after a revelatory year in Paris exploring the poetic, expressive potential of the human body and the powerful silences before and after words.

At the Lecoq School I had discovered the strength in my legs, the resistances in my muscles, understood the drama of my posture. I had embodied the paintings of Van Gogh, imitated the movement dynamics of a goldfish, cartwheeled, and walked on my hands. I had recognized the human body as powerfully poetic beyond words, that ‘everything moves’, and I had strived to discover what Lecoq called a ‘universal poetic sense’, a sensibility that there is poetry and movement in everything.

And suddenly I found myself in an environment, the hospital, which, paradoxically, seemed to have no physical awareness at all. Everything I had learned in Paris seemed frighteningly far away. Here I was in a hospital ward surrounded by unfamiliar props and objects, squeezed into an uncomfortable space under bright electric lights. I felt an extraordinary abyss between Lecoq’s view of the body as poetic and what seemed to be the medical establishment’s view of the body as something ‘to be cured’, of a person as a disease, of death as a failure. Although doctors were constantly dealing with bodies, they seemed very disconnected from their own, unaware of the impact their physicality was having on mine. The way that patients were touched and spoken to, with the best intentions, felt brutal to me. Medicine was an intellectual practice that seemed to limit and deny my experience of my own body. The health professionals weren’t being deliberately mean, they were trying to help. I wondered what they were learning about in medical school if not the sensitivities of the human body? The potential of the health professional’s body for creating an environment more conducive to healing was being completely ignored.

Just as Jacques Lecoq had wanted to bring a sense of physical dynamism to theatre – to preserve the qualities of movement and silence that he felt theatre had lost in its preoccupation with the written word (and by doing so, restore power to the word when it was used), I felt a strong desire to bring a sense of physical dynamism to medicine which, perhaps perversely, it seemed to be lacking.
In 1995, I created Clod Ensemble with musician Paul Clark to make performance work with music and movement at its heart. As well as making performances, the company has always had a commitment to education and participation programmes. Our Performing Medicine project gradually emerged through research and development across medical schools in the UK (Willson, 2006, 2007, 2014).

The project is primarily focused on using methods found in the arts (arts-based learning) to teach medical students and health professionals skills relevant to their clinical practice. Rather than being based on role-playing clinical scenarios (acting out what it is to be a good doctor), our approach introduces students to a variety of skills, ideas and processes: physical awareness, stamina, resilience, calm, teamwork, balance, concentration, voice skills, listening, observation, timing, confidence and flexibility, appreciation of difference and diversity. We work with students and professionals across several medical schools and within National Health Service (NHS) Trusts.¹ We also curate a programme of events for the general public, and some of our performance work draws on aspects of medicine, be it anatomy, patient experience or the medical gaze (e.g. An Anatomie in Four Quarters, Must and Under Glass; see References).

Although I have drawn on many actor-training techniques in designing the Performing Medicine programme, I have been particularly influenced by the teaching of Jacques Lecoq, who had a profound insight into the way human beings relate physically to themselves, each other and the world around them. Lecoq understood that the way we move defines and characterises us, that verbal language is only a small part of communication. Human beings think with their whole bodies. We absorb, copy, manipulate and identify with gestures, and every movement carries meaning, intentionally or not. We read each other's bodies; the rhythm of a walk, gait and posture tells us a lot about people's behavior and their habitat. Clearly, this is relevant to questions of health and well-being and has much to offer a medical education system that has its own well-established ways of intensively studying the body.

What makes Lecoq's work so useful in a medical context is that it does not veer towards the mystic, esoteric or confessional – none of which would be well-received in a busy, secular medical school or hospital. Lecoq was not interested in guru worship, therapy, or even in the psychological process of his students. He was an unforgiving teacher in many ways, with a philosophy that could never be described as 'soft' or 'touchy feely'. Perhaps influenced by his early career in sports and physical therapy, his deeply analytical approach is remarkably suited to the enquiring mind of the medical student or the skeptical mind of many clinicians and so-called 'hard' scientists.

In my method of teaching I have always given priority to the external world over inner experience. In our work the search for self-enlightenment and for spiritual bliss has little attraction. The ego is superfluous. It is more important to observe how beings and objects move and how they find a reflection in us.

(Lecoq, 2000: 17)

**Medicine – an intellectual practice**

Lecoq's pedagogical vision was based on an idea that we learn through the body, that an integrated mind/body experience is not something that can be understood from books or purely intellectual enquiry. This seems particularly relevant to medical education, because medicine is centrally concerned with the body.
In *Theatre of Gesture and Movement*, Lecoq quotes the anthropologist Marcel Jousse:

Human beings think with their whole bodies; they are made up of complex gestures and reality is in them, without them, despite them. Human beings must be grasped from the soles of their feet to the tops of their heads. There is no such thing as an intelligent head. There is a whole human composite, which knows and mimes through its whole body.

(Jousse in Lecoq, 2006: 4)

As I began to investigate medical education, I came to realize that in some powerful sense, the experience of being a body had become removed from the discourse between doctors and patients, teachers and students. Furthermore, the ‘body’ is often not viewed as a whole but is mapped and compartmentalized. Of course, this compartmentalization is key to some of the spectacular successes of medicine over the last 200 years, but it has also brought challenges. The discourse of medicine is predominantly verbal, in which the body is reduced to the status of an instrument in need of repair: the thing referred to. Like so many other areas of post-enlightenment culture, modern medicine is still laboring under a Cartesian dualistic paradigm of mind and body – an immaterial mind trapped in an alien body – which has led to a neglect of medicine as an embodied as well as an intellectual practice.

Modern medicine is regarded as a predominantly scientific practice and, as such, the ideal of objectivity is omnipresent. This tradition of objectivity, which Foucault described as the ‘anatomo-clinical’ or medical gaze (2003: 179), has led to a detachment in the clinician – an idea that if we involve ourselves too much, we will either mess up the experiment or be too overwhelmed to be professionally effective. I believe that this detachment is responsible for what medical anthropologist Arthur Kleinman describes as an ‘absence of presence’ (Kleinman & Kleinman, 1997: 9) in the medical profession. This absence surely contributes to what is perceived by some patients as a lack of care and compassion in hospitals.

Lecoq’s work is designed to improve the stage presence of performers, and it can also improve the ‘stage presence’ of doctors. After all, charisma or ‘bedside manner’ is not necessarily something you are born with – it can be improved dramatically by acquiring practical skills, an awareness of how we move and how we talk. An intellectual understanding of the benefits of these things will not get you very far; improvement requires practical work and practice. An understanding of gesture, physicality, and use of space can make a huge difference to the way doctors communicate and perhaps even to the way they diagnose, leading to more respectful, holistic and emotionally informed patient care.

The idea of presence can act as a useful antidote to detached behavior in a medical context. Presence in a health-care encounter can be deconstructed into an ability to speak clearly; to listen carefully; to engage with the environment; to be in control of the messages your body is sending out; to be comfortable with intimacy, ambiguity and difference; and to be comfortable with your own body and the bodies of others. In other words, an ability to be in the present moment, to be there.

Most medical encounters are brief. Increasingly, there is no time for doctors to build lasting relationships with patients, and this is often used as a reason for why doctors become detached (Halpern, 2001). Instead, we need to practice being engaged even in the briefest encounter, to help the patient feel at ease and secure in their environment. Medicine is not a purely objective science. It requires judgment, quick decisions, some guesswork, instinct and sensitivity. Clearly, a doctor is using his or her body even while attempting to objectify the body of a patient. The body is central to perception, knowledge and understanding; areas
of subjectivity need nourishing, and doctors need support to understand and excel at the embodied practice of medicine, both for the sake of their patients and their own well-being. Doctors need to be scientifically rigorous, acutely observant, good at critical thinking and engaged with their patients.

For many working in fields of dance and theatre, where thinking and doing, sensing and moving are integrated and the idea of a mindful body is fundamental, the thought that these ideas are not fundamental to medical practice seems counter-intuitive, absurd even.

**An education in seeing**

Lecoq’s work is so useful in this context because he goes some way to resolving the tension between subjectivity and objectivity. *Observation* and *identification* are equally important and are enacted physically.

When a car tyre bursts, that’s not an opinion, it’s a fact. I observe. Opinions can be formulated afterwards, based on this observation of reality . . . for an observation to be made one must pay close attention to the living process, while trying to be as objective as possible.

(Lecoq, 2000: 19)

The Lecoq School provides an ‘education in seeing’, a precise observation and rigorous examination of ‘how it moves’ (not just people, but animals, materials, light, the passions, volcanoes, etc.). The backbone of Lecoq’s pedagogy is an analysis of movement, which brings a knowledge of how the human body works, of how life moves. Students deconstruct movement into component parts – analysing time, space, rhythm, tension, colour, fixed point, scale, constraint, intensity, equilibrium between a movement and its counter movement, compensation and accentuation. They observe ways that the anatomical structure moves and reacts in space – examining how, when we are afraid, the body contracts, shoulders rise, the head is protected; how pride rises up, shame bows its head.

In theatre and performance, Lecoq’s insistence on laws of movement is unfashionable at a time when subjectivity is the prevailing trend in aesthetics. But for medicine, his emphasis on universal movement dynamics based in the limitations of anatomical structure has a different resonance. Although I have challenged medicine’s emphasis on objectivity, Lecoq offers a subtle difference of perspective: he values objectivity but recognizes the important role of the other person’s body, the context and the environment – constantly acknowledging the interplay between our bodies, other peoples’ bodies and the spaces they inhabit.

So, although Lecoq sees these physical dynamics as having a universal aspect, bound by physical laws, he is attentive to how they are transposed, deviated, hidden or opposed by education or by tactical or diplomatic considerations which are peculiar to each individual, to each country or to each historical period.

(Lecoq, 2006: 8)

But the most important feature of Lecoq’s teaching is that students *embody* the dynamics they observe. Lecoq’s form of mime, crucially in this respect, involves an ‘identification’ with things in order to better understand them: ‘the action of miming becomes a form of knowledge’ (Lecoq, 2000: 22).
The use of physical exercises in scientific learning has begun to be explored. For example, science students may be encouraged to learn processes such as the formation of protein crystals by embodying these physically rather than reading about them (Myers, 2008, 2012, Forthcoming; Hay et al., 2013). However, this kind of embodied pedagogy is not common in medical education.

Lecoq’s idea was that through this watching and embodying, students develop a broad physical vocabulary and an understanding of their own body. He describes the ‘physical circuits’ that this process leaves in the body, which are reactivated by different texts or scenes. As a result of this process, Lecoq explains, ‘the actor can then speak from full physical awareness . . . Our bodies remember!’ (2000: 45).

The implication is that the more we know what things feel like in our own bodies, the more we can recognize qualities in others’ bodies. Interpreting someone else’s body requires skill and practice. What is the patient’s body saying? Where are they holding tension?

Every gesture seen sets off within us the resonance of the corresponding circuit, revealing to us an aspect of the other, as well as a part of ourselves.

(Lecoq, 2006: 6)

It’s as though one side of our skin is used to connect with the exterior world and the other side to connect with our own interior world.

(Lecoq, 2006: 112)

This understanding of physical empathy or identification at the core of Lecoq’s teaching not only resonates with the work of phenomenologists, but also with recent work in neuroscience and in dance. Neurophysiologist Vittorio Gallese and his colleagues coined the phrase ‘mirror neurons’ in 1998, and subsequent research has shown that there may be a whole range of different ‘mirror matching mechanisms’ present in the brain – proving that, if you watch a dancer leap, for instance, the neurons in your own brain that would fire if you were leaping, fire anyway (Gallese and Goldman, 1998; Gallese, 2010). The same process applies to ‘contagious’ or preconscious behaviour, like laughing or yawning, and points to a hold that gesture and movement have over subjectivity. Given that bodies are in continual relationship to other bodies around them and the spaces we inhabit, it makes sense that a doctor has some awareness and can exercise some control over the messages that his or her body is sending out and to the physical environment that they are creating.

I contend that heightened personal physical awareness can make doctors more able to read signs and symptoms in the patient, even if the patient is unaware of them. How doctors physically relate to people in vulnerable conditions, therefore, will affect the healing process.

One cannot read other people directly; each person conceals from the world a secret part of himself, out of fear or pride, or mistrust. This is what gestures of expression can reveal, without us realising it.

(Lecoq, 2006: 16)

**Learning through the body**

In Western culture, we do not think about things in terms of kinaesthetics or physicality very often, a pervading ‘commonsense’ mind/body dualism perhaps linked to the ‘recessive body’
phenomenon described by Mark Johnson (2007: 6). If we want to change something about our behaviour, we tend to start by trying to change our psychology. The idea that by changing our bodies we change our minds is rarely expressed, beyond the idea that you might feel better and live longer if you do some exercise, get plastic surgery, or buy a new outfit.

So, perhaps it is not surprising that medical students are not required to think about their own bodies very often. Students do get some non-verbal communication teaching within communication skills courses, but this is focused around a traditional psychology of body language. The body tends to be treated as an instrument of the mind, to be manipulated as part of a rational strategy of behaviour. Traditional body language training, although useful to an extent, is often quite formulaic, offering set expressions for the body in particular situations rather than encouraging a broader, more flexible, personal physical awareness.

Lecoq's training is different. Students learn to be physically open, to put their bodies into a state of discovery, to find a physical readiness. By freeing the body from unnecessary tensions and rendering it more supple and flexible, perhaps they also become more supple and flexible mentally. Most medical students aspire to being calm, strong, flexible, balanced, alert, confident doctors. These are physical qualities, not just psychological ones.

Performing Medicine classes encourage students to listen to their bodies, so that they can recognise the tension they are carrying before they are alerted to it because they are in pain, and that they can do something about it before it begins to negatively affect both them and their patients. We encourage them to warm up and warm down before and after a busy shift – just as physical performers or dancers would do before and after a show.

When I work with medical students, Lecoq's fundamental reference point of ‘neutrality’ underpins everything. For people untrained physically, there is often a split between what they appear to be thinking and what they are thinking, as ‘the things people say and their behaviour while saying them do not always fit together’ (Lecoq, 2006: 6). Doctors might think they are being ‘neutral’, but often their body language is speaking very loudly, transferring stress, fatigue or moral judgment to patients.

The neutral mask is a tool used to encourage an energetic, dynamic, articulate body. It brings a sense of stability and a direct relationship with space. Students strip away outward personalities, mannerisms, habits, vanities, neuroses and ticks – they become adaptable, flexible, ready to respond to different environments.

Essentially the neutral mask opens up the actor to the space around him. It puts him in a state of discovery, of openness, of freedom to receive. It allows him to watch, hear, to feel to touch elementary things with the freshness of new beginnings.

(Lecoq, 2000: 38)

Although I rarely actually use neutral masks with medical students and health-care workers, I help them to find a neutral state. A calm, balanced, responsive body is a good place from which to begin a relationship with a patient.
For those who in life are always in conflict with themselves, with their own bodies, the neutral mask helps them to find a stable position where they can breathe freely.

(Lecoq, 2000: 38)

Through exercises derived from techniques drawing on Feldenkrais Method and yoga as well as Lecoq’s classic exercise ‘Seven States of Tension’, medical students and professionals become aware of the way they may come across to patients, and they abandon habits that get in the way of a clear dialogue. They are encouraged to broaden their physical vocabulary so they can be more effective in a range of situations, adapting their body language to the demands of each situation rather than getting fixed in one physical ‘attitude’ or archetype, such as ‘the hero’.

Lecoq understood the ways physical actions inform ideas and vice versa. A small teaching intervention might be able to affect some cultural change, as Lecoq memorably describes in an anecdote about his time in Germany after the war:

I like to think I helped a little in the ‘denazification’ of Germany: I tried out a relaxation exercise which consisted of lifting the arm and letting it drop. I found their way of doing it was stiffer and different to ours, so I taught them to loosen up.

(Lecoq, 2000: 6)

**Le jeu**

In a medical education, the style of learning is predominantly target driven; in a medical exam, many questions are multiple choice with answers that are right or wrong. This type of learning does not equip students to develop their critical thinking, nuanced response or tolerance of ambiguity, all of which are essential skills for a doctor. In order to imbue medical students with a sense of responsibility for their own learning, an understanding of how they function within a team and an ability to improvise around a task, medical education should move away from passive forms of learning and instead encourage the creativity of the student more actively.

Jacques Lecoq offered a lateral style of learning, a series of exercises and obstacles that forced students to come up with their own solutions; prescriptions were not offered.

The whole school works indirectly; we never proceed in a straight line towards a student’s desired goal.

(Lecoq, 2000: 53)

The idea of play or *le jeu* may seem at odds with the serious business of medicine, but perhaps it has an important role to play. *Le jeu* is an awareness of the audience, a pleasure in the action, a lightness of touch, a commitment to being alive and present in every moment. It is an understanding that everything is in relation to everything else and all elements play together: ‘neither belief or identification is enough – one must be genuinely able to play’ (Lecoq, 2000: 19).

**Poetic body**

Theatre and performance have ways of thinking about bodies as poetic, as places where memory is deposited, history is imprinted, culture is inscribed and the immediacy of feelings and
Moving medicine
desires is played out. The Performing Medicine project encourages health professionals to bring
something of themselves into the medical encounter so they do not become a mechanical
professional. We help health-care professionals to develop flexible boundaries and improve
their strength and stamina so that they can engage with patients without becoming over-
whelmed by the patients’ problems. They are encouraged to consider how they perform power
and status in relation to both patients and colleagues so that they neither feel intimidated
nor intimidate. They are encouraged to explore how a change in their physical attitude may
help to diffuse potentially aggressive or explosive situations. They are encouraged to under-
stand that they can use their own bodies in ways that can radically change the environment
in which they work, and to allow time and space to develop the real skills of openness and
responsiveness that Lecoq saw as prerequisites for the ‘poetic body’.
We are living in a world where there is always pain; it is how we interpret it that matters.

My hope, perhaps utopian, is for my students to be consummate livers of life and
complete artists on stage.

(Lecoq, 2000: 17)

On the medical stage, perhaps we could hope the same for our doctors and health-care
professionals.

Note
1 Practical workshops, seminars and performances are embedded in the enhanced curriculum at
Barts and The London Medical School, King’s College London and NHS Trusts across the UK.
In 2007, the project won the Times Higher Award for Excellence and Innovation in the Arts.

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**Clod ensemble performances**

**MUST**

MUST is published by Clod Ensemble and is available at www.clodensemble.com. It can also be found in:


**Under Glass**