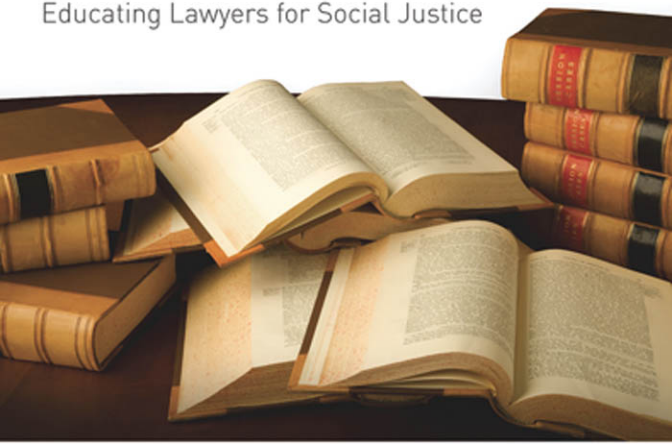
THE GLOBAL CLINICAL MOVEMENT

Educating Lawyers for Social Justice



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(Based on the Declaration of Principles jointly adopted by a Committee of the American Bar Association and a Committee of Publishers and Associations.)

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PREFACE

Twenty-five years ago—and ten years into my law teaching career—I found myself in the office of Dr. N.R. Madhava Menon, then the head of the Campus Law Centre of Delhi University. I had heard from colleagues in the United States that he and a few others in India, most notably Professor Upendra Baxi, were seeking to introduce clinical methods into India's tradition-bound system of legal education by establishing university-based legal aid clinics. I was about to apply for a Fulbright grant to teach abroad during an upcoming sabbatical year, and I was looking for a host institution where I could concentrate on legal aid and clinical legal education. As we mapped out plans for what turned out to be a wonderfully rewarding year for me with Dr. Menon and his colleagues, I had a sense that my life as a clinical legal educator was about to change dramatically. But I could not have imagined the richness of the experience that global clinical legal education would bring to me, both personally and professionally. This book presents much of what I have come to learn about global clinical education—in the words of many of the people who have taught me so much over the past twenty-five years.

Another catalyst for this book is the Global Alliance for Justice Education (GAJE). This book is not about GAJE, but the organization has had a pervasive influence on its content and production. Not coincidentally, the idea of GAJE—a global alliance of law teachers and others committed to achieving justice through education—was first floated at an internationally staffed "refresher course" for Indian clinical teachers organized by Dr. Menon. The first concrete steps toward establishing the organization were taken during a clinical conference organized by the Section on Clinical Legal Education of the Association of American Law Schools at which Dr. Menon gave the keynote address titled, "In Defense of Socially Relevant Legal Education." Many of the topics discussed in this book reference GAJE activities; most of the contributors to this book are among GAJE's 700-plus members, and most of them have participated in one or more of the five worldwide conferences that the organization has held over the past ten years.

One of clinical legal education's more popular themes is collaboration; collaboration between teacher and student, collaboration among clinicians, and collaboration across disciplines. It was my honor to orchestrate this particular collaboration among a group of extraordinary clinical law teachers, and I cannot thank them enough for their hard work on this project—in the face of the heavy competing demands placed on them by an active clinical practice. It was a pleasure to collaborate with colleagues who truly value the act of collaboration. I must also thank Vanderbilt University Law School for summer grant support that allowed me to develop and carry out the project, and to my alma mater, Columbia University Law School, for hosting me as a Scholar in Residence for a

semester of full-time editing. Finally, I want to offer special thanks to three Vanderbilt law students who provided me with invaluable research assistance: Colby Block (class of 2010), Erica Deray (class of 2011), and Donovan Borvan (who will graduate from the University of Chicago Law School in 2011).

The authors of several chapters wish to acknowledge persons who provided them with extraordinary assistance. The authors of Chapter 4 (Mariana Berbec-Rostas, Arkady Gutnikov, and Barbara Namyslowska-Gabrysiak) wish to thank Zaza Namoradze, director of the Budapest Office of the Open Society Justice Initiative and a pioneer in promoting and supporting the establishment of legal clinics in Central and Eastern Europe and countries of the former Soviet Union, for insights that he provided concerning the clinical movement in the region. The authors of Chapter 6 (Cai Yanmin and J.L. Pottenger, Jr.) would like to thank the many experts who reviewed earlier drafts of their chapter, particularly Jerome Cohen, James Feinerman, Jennifer Lyman, Pam Phan, Wang Chenguang, and Andrea Worden. The author of Chapter 8 (Diego Blázquez-Martín) wishes to thank his colleagues, Professor Maria Marques, Professor Antonio Madrid, and Vice Dean José García Añón, for providing additional information about clinical work at various universities in Spain. The author of Chapter 13 (Daniela Ikawa) wishes to thank Edwin Rekosh and Lusine Hovhannisian, colleagues at the Public Interest Law Institute, for their valuable comments on the chapter, and Adam Bodnar, Basia Namyslowska-Gabrysiak, Claudia Vazzoler, Filip Czernicki, Henrique Trevisani, Irene Maestro Guimarães, Renata Titina, Samuel Friedman, and Wanda Nowicka for agreeing to be interviewed and for the vital insights that they provided. The authors of Chapter 16 (Ajay Pandey and Sheena Shukkur) would like to thank Dr. Suri Sehgal, founder of the S.M. Sehgal Foundation and its Institute of Rural Research and Development (IRRAD) for the encouragement and support to the experiment of the unique legal literacy project described in the chapter, the villagers of Mewat and Ms. Aditi Jha and Mr. Navneet Narwal, colleagues at IRRAD who worked on the project, and also Professor C. Raj Kumar, vice chancellor of O.P. Jindal Global University and the dean of Jindal Global Law School, for his comments on the chapter. The authors of Chapter 19 (Margaret Martin Barry, Filip Czernicki, Izabela Kraśnicka, and Mao Ling) would like to thank the following clinicians for providing information concerning their respective countries: Dimitry Shabelnikov (Russia), Andrei Brighidin (Moldova), Maximilian Tomoszek (Czech Republic), Nigel Duncan (United Kingdom), Markiyan Duleba (Ukraine), Ernest Ojukwu (Nigeria), Jeff Giddings (Australia), Bruce Lasky (Southeast Asia), and Stephan van der Merwe (Republic of South Africa). Finally, the authors of Chapter 25 (Edward Santow and George Mukundi Wachira) would like to thank Professors Frank S. Bloch, Clark D. Cunningham, and Elizabeth Cooper for providing supplemental information about GAJE and GAJE activities.

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INTRODUCTION

FRANK S. BLOCH

At a workshop preceding the inaugural conference of the Global Alliance for Justice Education (GAJE) held in India in 1999, participants were asked to imagine a law school whose primary mission is to reduce injustice. The exercise started with the premise that law schools tend to see "the law" as the core subject of their educational mission and therefore tend to offer instruction that qualifies law students in an academic discipline rather than to practice in a profession. The exercise was intended, therefore, to highlight the need to focus law study not only on the concept of justice—as distinct from the law—but also on preparing future lawyers to root out injustice. A workshop setting was chosen to encourage the participants to approach the question of how to place justice—and how to achieve justice—at the center of legal education concretely and pragmatically. What would such a law school look like? What would make such a transformation possible? Are there any models now in existence? What barriers would block such a transformation? A wide range of proposals emerged during the workshop, with some concentrating on various ways a law school could be organized with justice as its central theme, while others focused on how law schools could target specific instances of injustice.

Two features of that workshop capture the essence of this book. First, the goal of the exercise was to begin a process of transforming legal education into justice education—and the obvious choice of means to achieve that transformation, as reflected in the proposals developed during the exercise, was clinical legal education and its core methodology of actively involving law students in their future professional role. Second, the workshop—and the full conference that followed—brought together an internationally diverse group of clinical teachers eager to share ideas and experiences in an effort to promote legal education reform around the world. This book is about a global clinical movement that first came to its own at that inaugural GAJE conference and its ongoing efforts to transform legal education into justice education by training lawyers for social justice.

GLOBAL CLINICAL LEGAL EDUCATION

There is a strong appeal these days to approaching just about any topic from a global perspective. But is there really something particularly meaningful about global clinical legal education—something more than simply that clinical legal education, like everything else, is "going global"? The answer is not all that

obvious, at least at first blush. There is an easier, more obvious case for global legal education in general. In today's world, no law school can afford to ignore global perspectives in its curriculum. And unlike traditional international law studies, which could be seen as relevant only to a handful of policy-makers, academics, and highly specialized practitioners, today's "global law" has a pervasive influence on people's lives and touches on almost every lawyer's law practice. That is why New York University touts its "Global Law Program," and why the Jindal Global Law School recently opened its doors outside New Delhi.

But clinical legal education is different. Clinical legal education is hands-on, professional skills training coupled with instruction in—and initiation into—lawyers' public and professional responsibilities. Clinicians teach law students about what lawyers do, what they should do, and how they should do it. And they teach about lawyering with experiential learning methods that place students in the role of a lawyer, preferably in a real-world setting in which they not only face, but also address, social injustice. Clinics are also where students learn about the local community and its legal needs—and how law and lawyers can address those needs. As a practical matter, therefore, clinical teaching has an inherently local dimension. And the same is true when one looks at clinical law teachers, at least as compared to their traditional academic counterparts. Most clinicians, and all who teach in real-client settings, are licensed lawyers. More often than not, they have had years of experience in the field that produced ties to the local community and the local bar. When they write, their best scholarship is informed by what they encounter in the field—often in their local clinical practice as clinical teachers—and many step out of academia for a tour in local law practice, public interest work, or government.

So what is the point of examining clinical legal education globally? First, and most obviously, is its global reach. Clinical programs exist today, in one form or another, at law schools throughout the world. Second is its commitment to providing "socially relevant legal education," a mission that resonates across any local-global divide. Finally, there is the collective energy of clinical law teachers throughout the world seeking out and joining with colleagues to share experience and advance common goals: the global clinical movement. These three aspects of what is happening in clinical legal education today—its global reach, its social justice mission, and its emergence as a worldwide movement—make the case for taking global clinical education seriously. Each is explored further below and in the chapters that follow, as they are also the themes of the three parts of this book.

THE GLOBAL REACH OF CLINICAL LEGAL EDUCATION

The chapters in Part I document the global reach of clinical legal education. Included in these chapters are descriptions of clinical programs in selected

countries in the Americas, Europe, Africa, Asia, and Australasia. Moreover, a comprehensive worldwide review of clinical legal education would reveal a global reach that extends to many more countries than those discussed in this book. There are, for example, a number of established clinical programs in various countries in the Middle East and there seems to be a growing interest in clinical education at law schools in Western Europe. Today, one could compile a list of clinical programs operating at law schools in every region of the world.

The fact that an impressive worldwide list of clinical programs can be compiled does not mean, however, that all clinical programs on the list meet some narrowly defined set of criteria that qualifies them to be listed. The list of clinical programs around the world consists of a variety of different types of clinics and clinical courses that can look quite different from one country or region to another—community legal centers in Australia, legal literacy projects in India, legal aid clinics in the United States, and *clinicas jurídicas* in Chile. Some differences are due to structural factors, such as whether law is taught as an undergraduate or a graduate course or whether additional postgraduate training is required before entering law practice. Others are due to economic and political conditions that influence the role that lawyers may or may not play in addressing social needs. What brings all these programs within the global reach of clinical legal education—despite inevitable differences in structure and content—is that they offer experientially based training in professional skills and values that emphasize critically important areas of professional and public interest that have been left out of the traditional law school curriculum.

The global reach of clinical legal education has importance beyond impressive numbers of law school clinics. With its focus on new areas of study, its links to social action, and its use of dramatically different teaching methods, clinical education has not been an easy sell. Clinical education's increasingly global presence gives the field a certain credibility that helps reformers establish new clinical programs. And as its global reach extends further—and the number of law school clinics grows—a momentum has begun to develop that has helped sustain existing clinical programs and ease the path toward institutionalizing clinical education. In other words, the global reach of clinical legal education has aided and facilitated its growth and acceptance. For example, the existence of clinical programs around the world has helped the Committee of Chinese Clinical Legal Educators push for expansion of clinical programs in China. Prominent examples of support for new clinical initiatives that reached across borders include South Africa's Association of University Legal Aid Institution's work in Nigeria that resulted in the establishment of the Nigerian Network of University Legal Aid Institutions and the efforts by the Polish Legal Clinics Foundation, the Russian Clinical Legal Education Foundation, and others to bolster clinical programs throughout their region.

THE SOCIAL JUSTICE MISSION

The chapters in Part II describe various aspects of clinical legal education's social justice mission and demonstrate how the global reach of clinical education has resulted in its social justice mission having an important global dimension as well. Although there has always been a strong link between clinical programs and legal aid or other forms of social justice work, those links were at first decidedly local. Many clinical legal education programs began as what amounted to law school-based legal aid offices. There are also many instances where law school projects focused entirely on a local social justice mission played a key role in developing new clinical programs. Promising to provide legal aid or other types of legal services to the community has been a very effective way to bring in funding for new clinical programs, particularly in developing countries. As a result, clinicians continue to work with their students mostly on cases and projects aimed at addressing social injustice in their local communities. And they have been concerned, for the most part, about legal education and legal system reform in their home countries.

This has begun to change, however, with the rise of a global clinical community. Clinicians and their students can now explore different ways that their clinical practices can serve not only their local clients but also those of their clinical colleagues around the world. A global approach to clinical education encourages faculty and students to become involved in projects dedicated to achieving social justice across borders and in other regions of the world. And as part of a global network, clinics can engage in a global social justice practice through a variety of specialized clinical projects.

Street Law is an example of a form of clinical education with a strong social justice component that has developed its mission and expanded its influence through the global clinical movement. The primary motivation of the first Street Law programs was local social justice; law students at Georgetown University went to local high schools in Washington, D.C., to instruct students about their legal rights. That experience was then shared with clinicians in other countries, which led to Street Law becoming part of the clinical curriculum at law schools around the world—in a variety of different forms tailored to meet the educational goals and social justice needs of the particular country. For example, Street Law came to South Africa when the country was beginning to free itself from the apartheid era, and Street Law clinics became a powerful tool for social change by demonstrating to law students their capacity—as public-minded lawyers—to promote greater awareness of civic rights. Insights gained while operating what was basically a locally framed project in South Africa modeled on a project begun in the United States have served to inform and enrich Street Law clinics throughout the world.

While practically any type of specialized clinical program can have a global dimension, two areas of specialized clinical practice involve obviously globally

significant work: human rights and immigration. In some human rights clinics, clinical teachers and their students literally cross borders to investigate and prosecute a wide range of human rights claims. In other instances, a particular case handled in a human rights clinic may benefit a local client but might also have implications for others around the world. Either way, clinical legal education's educational mission—and most particularly its social justice mission—includes engaging students in these types of matters as members of a socially responsible profession. Human rights clinics can have, therefore, an important influence on how future lawyers see the role of the law and the legal profession in a global society. Immigration clinics benefit from global clinical education in a different way. Typically, students in an immigration clinic carry out a local service; the client just happens to come from a foreign country. The global aspect comes with the need to cross borders and cultures while representing a local client. Thus, students handling an immigration case—whether the client is seeking refugee status or simply wants to continue a course of study—will often need to consult the law or investigate facts in another country. These types of clinics have flourished with the aid of personal and professional connections among clinicians across borders and regions that would not exist without a global clinical community.

THE GLOBAL CLINICAL MOVEMENT

Finally, we come to the global clinical movement. Does it really exist? As noted above, there is no doubt that clinical legal education has gone global. There are clinical programs at law schools all over the world, and clinical law teachers have been meeting together regularly at international conferences for many years. But a movement connotes something more than a widespread network of like-minded persons. Moreover, there are a number of substantial obstacles ahead. As noted above, much of what clinical education is all about—training future lawyers in professional skills and values—has an inherently local focus. Add to that the conservatism of the two institutions that clinical education seeks to reform—the legal profession and legal academia—and one might be inclined to bet against the chances of mounting a global clinical movement. The evidence on the ground shows otherwise.

The chapters in Part III demonstrate that a global clinical movement is already underway, one that draws on a commitment—shared by clinicians around the world—to reorienting legal education toward educating lawyers for social justice. While it is necessarily a multifaceted movement, it is gaining strength worldwide through the emergence of a common set of goals tied to preparing students for competent and ethical law practice. It gains strength also by maintaining a flexible approach to how clinical methods can be used to carry out those goals. There is, after all, more to global clinical legal education than the global

clinical movement. The process of forming a global clinical movement has itself brought about important advances in clinical education as clinicians have worked together at conferences, in workshops, and on specific clinical projects. With that in mind, the global movement should focus on what it is uniquely positioned to achieve, without undercutting valuable informal networking among clinicians or seeking to replace existing national and regional clinical organizations.

What we have today is a fledgling global clinical movement with tremendous opportunities for future growth. Communication across borders has never been easier. GAJE is the natural organization to coordinate the next steps in the evolution of the global clinical movement, but it need not—and should not—go it alone. National clinical organizations have begun to look beyond their own borders to support new clinical programs in their regions, most notably in Africa and Central and Eastern Europe. But the opportunity is not just to grow in numbers. If the global clinical movement is to take on the project that was simulated in the GAJE workshop exercise—transforming legal education into justice education—it must find ways to identify, encourage, and support innovative developments in clinical legal education around the world that can help achieve the movement's educational and social justice goals. This book seeks to set the stage for the global clinical movement to move that project forward.

PART I

THE GLOBAL REACH OF CLINICAL LEGAL EDUCATION

The chapters in this part, except for the last one, present the stories behind clinical legal education in different countries and regions of the world. The last chapter examines the global reach of clinical education in the context of debate over charges of "legal imperialism" ascribed to the law and development movement. Each of the first eight chapters tells its story from its own perspective and while each offers a full account of key developments, none is intended to be a comprehensive report on all that has happened in the field. Nor are all eight chapters together intended to provide a complete accounting of all clinical programs worldwide. They do not include, for example, programs that have existed for some time in several countries in the Middle East, nor do they cover all of the new programs in continental Western European countries that until recently have not been part of the clinical movement. These chapters do, however, provide an overview of most of the major clinical programs existing today—together with discussion and analysis of the various challenges that clinical programs face around the world.

Chapter 1 covers four countries that were among those that opened the era of modern clinical legal education. It describes the emergence of clinical programs in the United States, Britain, Canada, and Australia in the 1960s and 1970s and examines some of the key elements of those programs that have influenced the spread of clinical education around the world. Chapter 2 looks at the development of law clinics in selected countries in Southern, East, and West Africa, with somewhat more extensive discussion of pioneering work in South Africa. It also describes different approaches that clinical programs in the region have taken to the sometime competing goals of providing legal services and access to justice and teaching law students practical skills. Chapter 3 covers a group of Southeast Asian countries that have adopted clinical education relatively recently—Thailand, Malaysia, Indonesia, the Philippines, Vietnam, Laos, and Cambodia—along with India, which has been a leader in clinical legal education in South Asia since the 1970s. The chapter examines shared lessons and experiences in an effort to chart a way forward for clinical legal education in South and Southeast Asia.

Chapter 4 covers Central and Eastern Europe and includes a brief history of the development of clinical legal education in selected countries including Poland, Hungary, Bulgaria, Bosnia and Herzegovina, Serbia, Croatia, Russia,

and Ukraine. The chapter examines the role that clinical programs can play educating a new generation of lawyers from the perspective of countries in transition from totalitarian or authoritarian regimes to democracy. It also includes some observations about the opportunities and challenges for legal clinics within the wider European context. Chapter 5 looks at four countries in Latin America—Argentina, Chile, Colombia, and Mexico—and how clinical legal education has evolved in the region since the 1960s, when some early clinics received funds from the United States with the specific goal of training a cadre of modern lawyers to use law to address problems of social injustice and political corruption.

Chapter 6 examines the relatively recent but rapid rise of clinical legal education in China and how these new clinical programs operate within the current Chinese legal system. The chapter also looks at challenges clinics face and opportunities for further development in the larger context of social, economic, and political change taking place as a result of modernization. Chapter 7 analyzes the special case of clinical legal education in Japan, where clinical programs have been introduced as part of recent major reforms to the Japanese system for educating lawyers. While noting that the reforms recognize the need to train future lawyers in skills and professional values, the chapter identifies a number of institutional challenges that Japanese clinics continue to face. Chapter 8 looks at recent developments in Spain, one of the few countries in Western Europe other than the United Kingdom to implement clinical programs in the law school curriculum. In addition to describing various law school clinics in Spain, it explains how clinical legal education can serve to meet the goals of the Bologna Process throughout Europe.

This part concludes with Chapter 9, which explores the question whether the major influence that clinical legal education in the United States has had in other parts of the world can be considered imperialistic. The chapter finds no basis for such a charge, based on its analysis of the critique of the law and development movement from the 1970s onward—as well as its assessment of the social action role that clinical programs play in countries outside the United States and their focus on promoting the ethical responsibilities of the legal profession.

1. THE FIRST WAVE OF MODERN CLINICAL LEGAL EDUCATION
The United States, Britain, Canada, and Australia

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INTRODUCTION

This chapter considers the experiences of a group of early adopters of clinical education in the United States, Britain, Canada, and Australia. While important early developments occurred in other countries and in other parts of the world, clinicians in these countries laid the groundwork for the modern clinical movement and set the stage for its spread around the world.

There are many accounts of the history of particular clinical programs, generally written by an insider, someone involved in the clinic being described. The same attention has not been given to comparative accounts and to drawing together common threads. Why do clinics develop in particular ways in different countries? The emergence of clinics often appears tied to the development of legal education more broadly, but there are a number of other significant factors—social conditions, happenstance, regulation, as well as influential individuals and groups. In this chapter, we identify similarities in the emergence of clinics as well as variations around service expectations and the prominence of clinics within the academy. The similarities may tell us something about the essence of clinic-based learning.

THE EMERGENCE OF CLINICAL LEGAL EDUCATION

Clinics developed in each of these countries amid much broader social changes.[1] In the United States, the modern clinical movement "was born in the social ferment of the 1960's." (Schrag & Meltsner, 1998 at 3) In 1960s Australia, many law teachers at the newly established "red-brick" universities (as opposed to the well-established sandstone ones) were young "baby boomers" interested in developing new teaching approaches to enhance the case method of law teaching. The clinical movement burgeoned in Britain in the fertile environment of post-1968 Europe.

1. The influence of the legal aid movement on clinical education in these countries and others is discussed in detail in Chapter 10.

Against the background of youthful disillusion and labor dissatisfaction that changed the shape of European governments, the student unions and law schools of England established voluntary legal advice centers as part of a purposeful, measured movement that promised radical reform of legal education. In Canada, the movement for clinic-based legal education was inextricably bound up with the movement for community-based access to justice and other broader movements for social change and social justice in the 1970s. (Gavigan, 1999; Gavigan, 1997; Ewart, 1997) A cohort of law students and progressive faculty across the country challenged their law schools to provide a curriculum that addressed the lives and areas of law that affected the poor and dispossessed, while also challenging the legal profession to accept new ways and sites of providing legal services.

Many of these early clinical programs developed from volunteer arrangements. In the United States, for example, committed students at Yale began providing legal aid services—without receiving academic credit—in the late 1920s. "The academic faculty allowed the students to work in the legal aid offices but refused to award academic credit, considering the work to be outside the academic domain." (Holland, 1999 at 510) By 1930, Bradway noted five law schools with student volunteer clinics and another seven involved in "experimental efforts to use students in legal aid work." (Bradway, 1930 at 174) The strong community service focus of these fledgling clinics continued to be prominent in the more formal, for-academic credit clinical programs that emerged later, particularly in the late 1960s and 1970s.

Storefront legal clinics also began to appear in Canada in the early 1970s. "For the first time, law schools began to be pressed by students who wanted something different." (Gavigan, 1997 at 444) In 1970, Harry Arthurs had noted the "dramatic appeal" of clinical programs and the "outlet and reinforcement for the creativity and idealism of law students" they provided. (*Id.* at 448) Student commitment to legal aid service delivery was important in the establishment of Australia's first clinical programs as well. At Monash, volunteer students were pivotal in the establishment of Springvale Legal Service in 1973. From 1977, legal studies students at La Trobe University extended this commitment beyond law students, working as paralegals in a legal service center for fellow students. At the University of New South Wales (UNSW), law students were closely connected to the Redfern Legal Centre in the late 1970s. Although Redfern did not become the site for the UNSW clinic, a clear culture of voluntary involvement among students had been established.

Early Clinics in the United States

As law schools began to flourish in the early twentieth century, administrators attempted to distinguish their offerings from the apprenticeship path by focusing on analysis of legal doctrine stemming from appellate decisions. Although several institutions had nascent clinical programs, such as the University of

Pennsylvania's Legal Aid Dispensary established in 1893, this form of legal education was not given much weight as many future lawyers continued to opt for apprenticeships. A contrasting view was provided by a 1921 study by the Carnegie Foundation for the Advancement of Teaching, which noted that legal education was lacking in "clinical facilities or shopwork" as compared to engineering and medical education. (Rees, 1921 at 281) Around the same time, Reginald Heber Smith published *Justice and the Poor*, calling for the expansion and development of legal aid in order to make justice more accessible and fair. Suggestions that law schools should reach out to the burgeoning legal aid organizations to provide students with real world experience were met, however, with concerns about "practicability" from many school administrators. (*Id*. at 286) Throughout the 1930s and 1940s, a vocal minority of legal scholars criticized legal education for its inability to train lawyers to serve competently upon graduation and lauded the use of clinical programs to not only supplement students' education experiences, but to also bring legal services to those who needed them the most. (Frank, 1933; Bradway, 1930)

During the 1950s, the desire to focus on teaching students the "art of lawyering" resulted in the inclusion of research and writing courses, trial skills courses, and clinical programs in the curriculum. By the end of the 1950s, more than one-quarter of accredited law schools provided some sort of clinical education. The standards for these programs varied widely, as did the models used; a small number of schools even mandated participation in a clinical program, but at many schools students did not receive academic credit. (Barry et al., 2000) The level of supervision of the students varied greatly as well, with some clinical programs giving experienced students the responsibility for supervising less-experienced students. (Stevens, 1983) The major social issues of the 1960s and 1970s—poverty and civil rights, the women's movement, the Vietnam War—had a profound influence on the direction of clinical programs, leading to greater student demand and more specific focus on providing legal services in areas such as poverty law, civil rights, women's rights, consumer rights, and environmental protection.

Probably the most important factor at this time, from the late 1960s through the 1970s, was the decision by the Ford Foundation to fund the Council on Legal Education and Professional Responsibility (CLEPR). CLEPR and its president, William Pincus, built the foundation of clinical legal education in the United States as it is known today. Although many CLEPR grants—awarded to nearly half of the then-existing law schools within the first few years of its existence—were only temporary sources of funding, the resulting clinical programs were able to take root. Of the schools that received funding, few, if any, ceased operating the clinical programs after the funding ran out. Many other schools that witnessed the success of CLEPR-funded clinical programs were inspired to start programs of their own. (Schrag & Meltsner, 1998)

Early Clinics in Britain

The conditions in the 1970s were conducive to change. The impetus of social reform promoted by Sir William Beveridge and implemented by the post-war Labor government had introduced significant developments in health and education. Basic legal services were also available for a few, which had proved sufficient to reveal the inequalities of access to the vast majority. Unmet legal need had become a rallying call for those seeking further welfare reform. Both main political parties were alert to possible solutions, and in 1971 the government conducted a comprehensive review of legal education.[2]

A 1973 survey of legal advice in universities and polytechnics revealed wide provision of services to students by staff and/or students, with many extending services to the local community. (Britton, 1973) However, none of these advice centers were incorporated in the curriculum of a law school. The first clinic to be incorporated into the undergraduate curriculum in England was established at the University of Kent in 1973, followed by Warwick University in 1975. (Rees, 1975; Sherr, 1995) Other early clinical ventures were pursued at the polytechnics of the South Bank and Trent and the University of Brunel.

The Kent program for undergraduate law students was centered upon a law office that provided the full gamut of legal services to the local community. The clinic was led by a solicitor and volunteer practitioners who served as frontline advisers and supervised the students. Student experiences ranged from legal adviser and representative, to observer and participant in the administration of the clinic. A clinical law course was introduced into the curriculum at Warwick in 1975. It emanated from student, staff, and local practitioner collaboration in establishing local legal advice centers, initially for university students and subsequently for people with legal problems from surrounding communities. It began as a one-year elective course during which students attended local advice sessions with law school staff and soon became a fully operational live-client clinical course. The main objective of the Warwick Legal Practice Program, however, was "to provide a special form of legal education to law students" rather than a primary commitment to provide legal assistance. (Sherr, 1995 at 109) Other clinical programs at Warwick have included smaller courses focusing upon placements, practice-oriented research projects, and Street Law programs.

Clinical programs have flourished in the United Kingdom periodically at a significant number of law schools. Often because the live-client clinic has not been the sole or even main focus for clinical activities, they have evolved over time into different expressions of practical engagement. These developments have been the product of new blood, adjusted pedagogical objectives, resource pressures, educational policy, and political expediency. Kent's program is no exception.

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2. *Report of the Committee on Legal Education*, under the Chairmanship of Sir Roger Ormrod (Cmnd. 595).

In 1976 the clinic became embroiled in a political struggle with the factions in the university and the local legal community. (Smith, 1979) The incident was indicative of the sensibilities of university authorities and professional interests. It proved only to be a temporary setback for Kent, although it gave rise to wider anxieties for those contemplating setting up a clinic. The experience encouraged Warwick, for example, to outsource its advice clinics and distance the service element from the campus and university.

Clinics were neither as abundant nor as specialized as they have become in the United States. The UK engagement with clinical approaches has been distinctive because of the educational, professional, and social context that has shaped the process of lawyer education and training. Thus, while examples of simulations and role-play are widely used in UK law schools, a 1995 survey showed that only eight of the seventy-nine universities polled offered live-client clinics. Two law schools in the survey offered a full representation service, and six institutions offer advice only or partial (tribunal/arbitration) representation. (Grimes, 1995) On the other hand, Street Law as a form of clinical legal education has become quite prominent.[3]

Early Clinics in Canada

One might say that there were two expressions to the "first wave" of law school clinics in Canada in the early 1970s. Many law schools supported the creation of law student clinics housed in the law schools, often funded by provincial legal aid plans. Examples include University of Manitoba Legal Aid, Student Legal Services at the University of Alberta, Downtown Legal Services at the University of Toronto, Community Legal Advice Services Program at Osgoode Hall, and Community Legal Aid at University of Windsor. The law students in these clinics often were volunteers who received little or no academic credit for their clinic work. Their legal work, including representation of low-income clients, was supervised by one or two staff lawyers with little faculty involvement. In the province of Ontario, the model of these clinics was a student-run "student legal aid society," which provided an opportunity for students to represent clients in various matters.

Another model of the first wave found expression in clinics that were established and located in communities. In 1971, the federal government provided funding for four community legal clinics, three of which were deeply affiliated with law schools: Community Legal Services, Inc. of Point St. Charles in Montréal, Dalhousie Student Legal Aid, Osgoode Hall Law School (for Parkdale Community Legal Services (PCLS)), and Saskatoon Legal Assistance Society (associated with the College of Law, University of Saskatchewan). Each of these

3. Street Law clinics in the United Kingdom and elsewhere in the world are described in Chapter 15.

clinics had a broader vision of access to justice than conventional delivery of legal services and legal representation by law students for low-income people. They were committed to social change, the elimination of poverty, and community organizing and law reform. (Zemans, 1978; Garth, 1980) In 1974, the faculty of law at the University of Windsor added Legal Assistance Windsor (LAW), with its express commitment to an interdisciplinary approach of law and social work/social policy, to this pioneering cohort of clinics. (Voyvodic & Medcalf, 2004)

The legal educational implications of the first wave's social justice objectives cannot be overstated. For Parkdale's first director, Fred Zemans, Osgoode's development of this poverty law program had two central elements: "exploring the possibilities of clinical legal education and developing an alternative model of legal aid services." (Zemans, 1997 at 503) There was, however, a "dynamic tension" from the beginning between the law school and the clinic—not least because in the early period, clinical education was called "clinical training," and this appellation ensured that concern, if not outright resistance, would be expressed by some faculty members. For Osgoode's Harry Arthurs, a formidable skeptic, the "role of intellectualism [would] be further diminished." (Gavigan, 1997 at 449) Its academic rigor thus suspect, clinical education was also seen as a "competitor for the soul of legal education ... [and] a device for anchoring the law school more solidly with the legal profession." (Voyvodic & Metcalf, 2004 at 106 n. 13) New clinical programs have continued to be created at Osgoode Hall; these programs are smaller, involving fewer academic credits and fewer students, but they still provide students with the opportunity to work with clients while integrating theory and practice.

Emergence of Early Clinics in Australia

As noted earlier, Australia's earliest clinical programs—at Monash University, La Trobe University, and the University of New South Wales (UNSW)—involved newly established law schools with young academics and socially active students. Monash Law School developed Australia's first clinical program, with students being the driving force behind its establishment in 1975. The La Trobe University clinical program can be traced to the 1974 establishment of the La Trobe Legal Service by staff from the Legal Studies Department. La Trobe did not offer a law degree at that time, but had developed related socio-legal studies; there was strong student demand both for the provision of legal services to the student population and for involvement in the delivery of those services. (Evans, 1978) The UNSW law school explored the possibility of developing a clinical program with the Redfern Legal Center, but this met with resistance from some involved in the center due to independence concerns. The law school established its in-house clinical legal education program in 1981 with the opening of Kingsford Legal Centre, a move prompted in part by the recently established UNSW seeking to challenge the preeminence of Sydney University.

Interest in clinical legal education was reactivated following a range of reforms to the university sector in 1987 that expanded the number of law schools dramatically, with a number of the newly established "third-wave" law schools considering the establishment of clinical programs. (McInnis & Marginson, 1994) The mid-1990s saw the establishment of prominent clinical programs at Newcastle University, Murdoch University, and Griffith University. The live-client model has been most prominent, with some law schools also characterizing simulation-based and placement activities as clinical. Clinic appears to have been viewed by some new law schools as a means of differentiating themselves from other new law programs in an increasingly competitive environment. The clinic-oriented law degree at the University of Newcastle is the largest and most ambitious of these new programs. The Newcastle program enables students to combine the academic and vocational stages of their law studies, satisfying the practical legal training requirements by way of involvement in a range of clinical activities. (Boersig, 1996) Most Australian clinical programs have benefited greatly from continuity of key staff. Monash and La Trobe have both had senior academics remain involved in their respective clinical programs for more than twenty years, while UNSW has benefited from a series of long-term contributions. Griffith and Murdoch have also had key staff remain involved since the inception of their programs in the mid-1990s.

COMMON AND CONTRASTING EXPERIENCES

This section examines common threads from the different countries as well as those aspects where the experiences differ. External factors impacted on these early clinics as they developed their particular approaches to law teaching and service delivery. Resourcing issues have been prominent in the development and continuing operation of these clinical pioneers.

Impact of Education Policy

Most law schools in the United States now extol the virtues of their clinical offerings to a wide range of constituencies. However, had CLEPR—and later the US Department of Education—not provided substantial external funding to law schools to develop clinical programs, clinical legal education would likely have remained a marginal development. Since that time, clinical programs have had to compete with other parts of the law school for their share of the budget. Although many law schools have now embraced the value of having strong clinical programs and some have obtained sizable endowments to guarantee ongoing funds, clinics remain vulnerable—especially at law schools where clinical faculty have only a limited role in law school governance.

The environment has been conducive to the introduction of clinical methods in the United Kingdom since the 1980s, when undergraduate education became

a focus for government regulation and quality assurance. Higher education reforms have promoted experiential and practice-oriented learning, promoting problem-solving approaches and diversity of learning methods. However, not all of the government's policy initiatives have been beneficial for clinical programs. The professions became more distanced from the academies as national and European education policy, rather than professional competence, became the primary lever of higher education reform. Moreover, the rapid expansion of higher education exacerbated the resource tensions. Professional supervision of student casework by clinical teachers for large numbers of students has always fared badly in comparison with the traditional "pile-them-high-and-teach-them-cheap" lecturing model. The government's funding model continues to treat law among the cheapest disciplines to teach. Successful clinical programs have consequently either been elective or purely voluntary. On the other hand, the government has supported a recent trend for large-scale student engagement in the community. The attorney general, in conjunction with city firms and the bar, are vigorously promoting pro bono student activities—emphasizing, as have law school clinics, professional altruism alongside educational improvement and career development.

The impact of changes in education policy on clinical education has been most dramatic in Australia, where moves toward a mass participation model of higher education contributed to the emergence of new law schools. The sweeping reforms to higher education instituted by the federal Labor government in the late 1980s freed up the processes required of universities to establish new schools. With the number of law schools doubling between 1989 and 2003—from twelve to twenty-four—the newer law schools were a significant force in building the momentum of the Australian clinical movement. (Johnstone & Vignaendra, 2003)

Opposition from Outside

Canadian clinics faced early opposition from the practicing profession. The clinic at the Windsor law school, for example, "faced concerted opposition from Windsor's private bar, which strenuously opposed the entry of law students into the city's courtrooms on the grounds that they lacked professional qualifications and would therefore put clients at risk. Some members of the judiciary also expressed this opposition, refusing to permit law students to appear." (Voyvodic & Medcalf, 2004 at 112) The clinical program established by the Osgoode Hall Law School in the early 1970s faced initial opposition from the Law Society of Upper Canada, particularly in relation to the clinic's role in the delivery of legal aid services. The law school agreed that the clinic would only assist people who could not obtain legal services elsewhere, and that it would neither act for paying clients nor compete with private practitioners who handled primarily criminal and family law cases under the judicare scheme. (Zemens, 1997) The fledgling Parkdale Clinic subsequently enjoyed great support from significant others in the legal profession, not least the then Attorney General (and later Chief Justice of Ontario)

Roy McMurtry, Samuel Grange (later a judge of the Ontario Court of Appeal), and numerous lawyers who gave generously of their time and expertise to support students and the board of directors. (Ellis, 1997)

The UNSW law school encountered significant resistance from the Law Society of New South Wales to the establishment of its clinical program, Kingsford Legal Centre. This resistance was due in part to the law school's links to Redfern Legal Centre, a very prominent and radical community legal center. Staff and volunteers at Redfern were behind the establishment of the Australian Legal Workers Group, which was setting itself up as the alternative law society for radical young lawyers. The director of the UNSW clinic thus had to negotiate with the President and Secretary of the Law Society not only about the opening of Kingsford, but also about what type of practicing certificate the law society would give him. After several months of difficult negotiations, the Law Society backed off and issued him the required practicing certificate.

In England, the Kent clinic faced early difficulties on a range of fronts. While receiving considerable support from radical practitioners and some elements within the professional establishment, self-interested local solicitors were concerned that "some of their potential clients were obtaining free legal services at the clinic." (Smith, 1979 at 10) In addition, the university senate became unhappy with the political and public nature of the cases taken on by the clinic. These included a series of cases where the clinic acted for students against the university, represented city refuse collectors in an action against the city council, and led an inquiry into the management of a psychiatric hospital, one of whose board members was the wife of the university vice chancellor. (McFarlane, 1988 at 149; Smith, 1979 at 9) The clinic also represented a journalist accused of spying on the Central Intelligence Agency of the US government.

The highly politicized nature of the legal work done by some clinical programs in the United States—together with the limited availability of alternative legal aid services—have resulted in certain clinics facing very strong opposition from powerful political interests, including state governments. Indeed, some attempts have been made to have universities close down clinical programs. In a comprehensive outline of attempts at such political interference, Kuehn and Joy explain that the "interests of politicians and of university alumni and donors add an additional level of outside interest and potential interference in law school clinic activities." (Kuehn & Joy, 2003 at 1974)

Interest in Professionalism and Ethics

Much has been written about the suitability of clinic-based learning while at law school for fostering the ethical awareness and professional responsibility standards of practicing lawyers.[4] Concerns regarding ethics were clearly prominent in both the establishment and development of clinical programs in the United

4. Ethics and professionalism is the topic of Chapter 12.

States and Canada, and have become increasingly significant for Australian and UK programs.

The Canadian experience with clinical legal education, notably in those clinics engaged in community-based poverty law legal services, afforded myriad opportunities for student engagement with—and critical interrogation of—legal ethics and professional responsibility. As one of the early clinicians in Canada observed, in reflecting upon his own experience in the 1970s, "the concept of a community-based legal clinic delivering legal services is an inherently radical idea" rendered even more complex when law students possessed of "disconcertingly high ideals but often little experience" are on the front lines. (Ellis, 1997 at 571)

From the outset, the Parkdale Clinic challenged the profession's strictures against advertising; even more challenging were some of the early client services decisions that the clinic made, including a policy not to represent landlords, even indigent landlords, in landlord and tenant disputes. (Zemens, 1997; Elis, 1997) One of the most controversial policy decisions taken by the Parkdale Clinic involved a decision not to represent male clients in matters where spousal assault is an issue, unless unable to find other legal representation for the man. These policies illustrate the sorts of challenges that these clinical programs presented—not only to the traditional approach to the delivery of legal services, but also for students who were required to grapple with the transformative potential and political (and educational and professional) implications of alternative approaches to the practice of law. (White, 1997; Mosher, 1997) Significantly, students in these programs have made significant contributions to the professional literature that reflect their experience with their clients and the community, their critical engagement with clinic polices and professionalism, and poverty law and law reform more generally. (*e.g.*, Robertson, 1997; Romano, 1997; Rachin, 1997)

As noted earlier, improving law school training in professional responsibility was one of the key goals of CLEPR as it was funding the US clinical movement in the 1970s. In addition, at around the same time, the legal profession was deeply affected by the aftermath of the Watergate scandal of the early 1970s. The large-scale involvement of lawyers in the Watergate cover-up (Richard Nixon himself was a lawyer), prompted a public demand for federal regulation of the profession. The then Chief Justice of the United States, Warren Berger, spoke out on the subject. As a result, the American Bar Association (ABA) instituted several major reforms regarding professional responsibility and ethics, including the mandate that all students at ABA-accredited schools take a course in professional responsibility and ethics. Many students and administrators recognized that clinical programs served as training grounds for this new focus in legal education by presenting students with ethical dilemmas in practice and testing their ability to solve those problems.

Clinics, particularly live-client clinics, have long been recognized in the United Kingdom for the opportunities they present for ethical inquiry and development inherent in the student-client experience. The capacity for clinics to address

ethical concerns has also been recognized in government proposals for legal education reform.[5] Clinical teachers have consistently espoused the professional importance of clinical methods as a vehicle for ethical awareness and appreciation. Experiential methods are at their most valuable when they can embrace ethical issues as part of a holistic approach to legal understanding. (Webb, 1996) In this regard, it is salutary to reflect on the pedagogic implications of Kent Law School's experience of the "politics of representation" described above.

The ethics focus of Australian clinical legal education has been articulated more clearly in recent years. Styles and Zariski have referred to the increasing importance of legal education goals related to the development of professional ethics and student-centered learning, along with the development of student understanding of the relationship between theory and practice and the development of technical skills. They consider clinics well placed to counter some of the negative influences of traditional legal education on students' commitment to the public interest. (Styles & Zariski, 2001) Dickson and Noone rightly note that the clinical setting "constantly gives rise to spontaneous and various ethical questions which challenge and test students." (Dickson & Noone, 1996 at 847) Given that written ethical conduct rules cannot cover every possible circumstance, clinics provide students with opportunities to develop the ability to identify and address ethical issues in relation to a wide variety of matters, including conflict of interest, confidentiality, and legal professional privilege. The 2007 Best Practices Report published in the United States has similarly called for law schools to expand their use of experiential education as "a powerful tool for forming professional habits and understandings." (Stuckey and Others, 2007 at 123)

POINTS OF CONTRAST

Clinics develop in ways that reflect the particular circumstances and concerns of different nations. The clinical movement in the United States is considerably more prominent than in the other countries addressed in this chapter. It has achieved a greater sense of critical mass, in large part through the presence of professional accreditation requirements that promote clinic-based learning for law students. Nonetheless, as recently as 2007 the Carnegie Report referred to clinical training in the United States as "the underdeveloped area of legal pedagogy." (Sullivan et al., 2007 at 24)

The Academic–Professional Divide in Legal Education

In the United States, a written examination—administered by each individual state—is now the standard method for qualifying for admission to the bar.

5. Lord Chancellor's Advisory Committee on Legal Education and Conduct, First Report on Legal Education and Training, ACLEC 1996, HMSO, London.

Obviously, the need for law schools to prepare graduates for entry into the profession is particularly acute in a system that does not rely on or require apprenticeships. This absence of a requirement for law graduates to complete a vocation-focused professional program prior to admission to practice has thus shaped the expectation in the United States that law schools play a substantial role in preparing students for the practice of law. It is also likely to have fostered the greater prominence of clinics in the United States as compared to Australia and the United Kingdom, where legal education continues to be divided into academic and professional stages, albeit with some law schools delivering both stages.

More clinics might have developed and flourished in the United Kingdom were it not for the success of the vocational postgraduate programs organized by the Law Society and the General Council of the Bar. The UK professions, unlike their US counterparts, have long required the successful completion of a year-long program of practical education and training for those seeking admission to practice. Such practically oriented training relieves the "academic stage" providers from the obligation to incorporate professional concerns in their degrees or conversion programs. As a result, many vocational programs have become active in promoting clinics. The Inns of Court School of Law, for example, offers live-client opportunities in conjunction with the charity, the Free Representation Unit. The College of Law, which delivers professional programs at seven centers in England, runs five legal advice clinics. The Bar Council—and recently the Bar Standards Board—encourages providers of its Bar Vocational Course to include clinics as an option. The University of Northumbria offers a program unique in the United Kingdom, combining the academic and vocational stages in a single curriculum.

While relying on a system of professional education similar to that of the United Kingdom, Australian vocational programs, with the exception of Newcastle Law School, have not been as prominent as advocates for clinic-based learning. Newcastle was the first Australian law school to offer a program combining completion of a law degree with this professional requirement. Newcastle law students could choose to complete either a standard law degree or to enter the "Professional Program," which enabled students to obtain a restricted right of legal practice immediately upon graduation. Other Australian law schools which operate professional programs have continued to rely heavily on simulations, supplemented by work placement arrangements which do not involve close direct supervision by program staff. Monash clinicians were heavily involved in the development of the law school's vocational program in 1999, incorporating a substantial clinical component. However, that program was discontinued in 2007 due to university requirements that such postgraduate programs generate substantial revenue streams.

Accreditation Requirements

The American Bar Association (ABA) has strongly supported clinical programs in the United States through its authority to accredit law schools authorized to

graduate students qualified to sit for the bar examination in every state. The requirements for law schools to gain ABA accreditation include making clinical experiences available to students. The ABA has also given preference to in-house models of clinical education over externship arrangements; ABA scrutiny of externships is more detailed, and limits are placed on the amount of credit that can be given to clinical work that does not involve direct supervision by law school faculty or staff employed by the law school. (Joy, 2004) The ABA also promoted the student practice rules critical to running live-client clinics and, as discussed below, supported efforts to increase the status of clinical faculty.

This strong institutional support of clinics by the practicing profession contrasts with the relative lack of prescription in both the United Kingdom and Australia, where the professions have not been as actively supportive. The focus of Australian legal professional regulators has been on ensuring coverage by each law school of particular areas of substantive law rather than on the approaches used to foster student learning. Regulators have also relied on the practical orientation of the vocational phase of Australian legal education to prepare law graduates for practice. The implications of the split pathways to professional qualification in the United Kingdom—between a knowledge-focused academic stage and a practically oriented professional one—have marginalized the holistic potential of clinical methods. The academic undergraduate stage of legal study concentrates on the acquisition of the knowledge and analytical skills appropriate for a liberal higher education program and is reflected in the career destination of graduates, less than 50 percent of whom enter the legal profession.

Funding

A key difficulty for law teaching and a factor limiting the further development of clinical legal education in Australia is the Relative Funding Model used by the federal government since 1991 for the allocation of operating grants to universities. Law was placed in the bottom discipline cluster, along with economics, accounting, and various humanities. The least expensive ways of teaching have become the default position for Australian law schools. In the absence of a strong tradition of clinic-based experiential learning in law and with law funded at a minimal level, it is less likely that law schools will prioritize clinical programs given that they are a relatively expensive form of legal education. The establishment of the Southern Communities Advocacy Law Education Service (SCALES) by Murdoch University in 1997 was therefore a significant development, as SCALES was the first clinical program to receive direct federal government funding—and continues to receive funding—as one of four programs supported by a small clinical legal education funding program included in the 1998 federal budget. For the past decade, the federal Attorney-General's Department has directly supported the clinical programs at Griffith, Monash, Murdoch, and UNSW.

The UK experience is similar to that in Australia, with the funding of undergraduate law programs in the lowest band for government support of university teaching. Moreover, the government awards additional funding to those universities and law schools which are most research-active; although opportunities for law schools to achieve significant research funding are relatively scarce, the quest for research outputs and scholarly reputation further eclipses clinical ventures.

Clinical legal education is funded in the United States for the most part through each university's regular budget process. This places clinical programs in a relatively strong position, as they are an important component of both public and private law schools. The problem, as noted earlier, is that clinics must compete with other law school programs and can be vulnerable—given their relatively higher cost—in times of economic stress. Clinics might be thought to have an advantage at public universities since they provide a direct public service, but most publicly funded law schools receive only a small percentage of their support from state funds.

Clinics in Canada have had to face funding uncertainties—the Dalhousie clinic was almost forced to close when the law school experienced a funding crisis in the early 1990s—related not just to supporting clinical legal education, but also support for legal aid more generally. The Saskatoon Legal Assistance Clinic (and the College of Law) had made an enormous, shaping contribution to the form of the first comprehensive legal aid plan in Saskatchewan in 1974. But then, following a change in government and subsequent restructuring of legal aid (notably the elimination of any form of community governance or boards), the legal aid plan withdrew from its partnership in the clinical program in 1983—and the College of Law was unable to continue it on its own after the 1986–87 academic year.

Treatment of Clinical Academics

Wherever clinics have been established, concerns have been raised in relation to the marginalization of clinical academics. This may be more of an issue in the United States because of the broader acceptance of clinical teaching. The more you have, the more you have to lose.

Clinical teachers in the United States, as a group, have always been treated to some degree as second class by the legal academy. In the 1970s, CLEPR provided a series of grants to augment the salaries of clinical faculty relative to those of classroom teachers, in an effort to aid in the recruitment and retention of skilled clinical faculty. By doing so, CLEPR hoped to bring legitimacy not only to the role of the clinical faculty within law schools, but also to clinical legal education as a whole. (Joy & Kuehn, 2008) While some progress was made, Schrag and Meltsner noted—referring to a 1978 CLEPR report that only 14 percent of full-time clinicians held tenure-track positions—that the lack of status and equal treatment of clinic staff was "the most difficult issue facing clinical legal education." (Schrag & Meltsner, 1998 at 8) In 1980, the ABA and the Association of American Law Schools issued a joint report on clinical education that echoed many of CLEPR's