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Musings on a Clinic Report: A Selective Agenda for Clinical Legal Education in the 1990's

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INTRODUCTION

In 1986, the Clinical Legal Education Section of the American Association of Law Schools (AALS) created the Committee on the Future of the In-House Clinic. The Committee's task was to examine a broad range of issues related to live-client, in-house clinical education.[1]

After four years of data gathering and analysis, the Committee has now issued the *Final Report of the Committee on the Future of the In-House Clinic*.[2] The Report is an ambitious undertaking that accomplishes some of the Committee's objectives better than others. The Report's primary accomplishment is to provide a comprehensive assessment of the current status of clinical legal education from the perspective of clinical educators. Through its detailed portrayal of the present state of clinical education, the Report also will likely set the agenda for future discourse on the role of the clinic in legal education.

This Essay discusses some of the issues raised by the Report from my particular perspective as a legal educator who divides his time between both clinical and nonclinical teaching.[3] The Essay is not intended as a comprehensive examination or critique of the Report. Instead, this Essay focuses on five issues

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1. *See* Palm, *Message from the Chair*, AALS SEC. ON CLINICAL EDUC. NEWSL. 1-2 (April 1986).

2. AALS SECTION ON CLINICAL LEGAL EDUCATION, FINAL REPORT OF THE COMMITTEE ON THE FUTURE OF THE IN-HOUSE CLINIC (August 1990) [hereinafter THE REPORT]. At this time, the AALS Section on Clinical Eduction has not published the report, although it has widely circulated the report and is scheduled to present it at the 1991 AALS annual meeting in Washington, D.C.

3. The author is the Director of the Civil Clinics and teaches in the Civil Practice Clinic and the Public Interest Law Clinic. He also teaches nonclinical courses in Labor Law and Employment Law.

that will be in the forefront of the clinical legal education agenda for the 1990s.

I. THE REPORT

The impetus for the Committee and its Report was Professor Gary Palm, then chair of the Clinical Section and long-time clinic director at the University of Chicago. Professor Palm requested that the Committee examine whether "live client clinical education ha[d] remained stagnant."[4] To this end, he suggested that the Committee explore a number of sub-issues, including faculty status, funding, clinician "burnout," clinical scholarship and the appropriate range of the clinic caseload.[5]

To accomplish this task, the Committee organized itself into five subcommittees, each charged with responsibility for a specific sub-topic. The five subcommittees prepared drafts that, in turn, became the five sections of the Report. The Report addresses the following sub-topics:

1. pedagogical goals of in-house, live-client clinics;[6]
2. data collection;
3. working conditions for clinical teachers;
4. guidelines for in-house clinics; and
5. recommendations to the Section's leadership.[7]

The 107-page Report is not without its flaws. The Report was prepared solely by clinicians. Although it provides an important perspective, the additional input of nonclinicians would not only have broadened the debate, but also would have shielded the Report from criticism that it is self-serving. This

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4. THE REPORT, *supra* note 2, at i-ii.
5. *Id.* at i n.1.
6. The Report defines "in-house, live-client clinical education" as follows:

> Clinical education is first and foremost a method of teaching. Among the principal aspects of that method are that students are confronted with problem situations of the sort that lawyers confront in practice; the students deal with the problem in role; the students are required to interact with others in attempts to identify and solve the problem; and, perhaps most critically, the student performance is subjected to intensive critical review.
>
> If these characteristics define clinical teaching, then the live-client clinic adds to the definition the requirement that at least some of the interaction in role be in real situations rather than in make-believe ones. . . .
>
> The in-house clinic further supplements the definition of clinical education by adding the requirement that the supervision and review of the student's actual case (or matter) be undertaken by clinical teachers rather than by practitioners outside the law school.

Id. § I, at 1-2.
7. *Id.* at i-iii.

exclusive reliance on the clinical perspective is particularly troublesome in the data collection section.[8] In this section, the statistical survey too often relies on the subjective views of clinicians rather than seeking objective data. For example, the subcommittee reports the perceptions of clinicians as to student demand for clinical education[9] and the extent of funding for clinical programs[10] instead of objective data in the form of enrollment or budgetary figures.

Despite its flaws, the Report is a major accomplishment. Its principal achievement is a broad-based description of the current status of live-client clinical education and the collective viewpoint of clinical educators. In particular, the data collection section, although lacking in some respects, makes a significant contribution. That section provides the first comprehensive status report in the twenty-five year lifespan of clinical legal education. This depiction of the present, even more than the Report's actual list of recommendations, establishes the starting point for assessing the future of the law clinic. This Essay begins that assessment by exploring five of the most significant topics discussed in the Report.

II. THE ISSUES — AN AGENDA FOR THE 1990s

A. THE ALLEGED DECLINE OF THE LIVE-CLIENT CLINIC

One of the principal goals of the Committee was to ascertain whether the rumored "stagnation" in live-client clinical education was real or fictitious. During the 1980s, anecdotal evidence suggested a possible decline in clinic enrollment. Faced with budgetary problems, some law schools focused on the relatively high cost of live-client clinical education as a means to ease the pressure.[11] Alternative and less expensive methods of skills instruction, such as simulation-based courses and externships, grew in popularity.[12] Some legal educators

8. *See id.* § II.
9. *See id.* § II, at 17-22.
10. *See id.* § II at 7, 13.
11. *See* LaFrance, *Clinical Education and the Year 2010*, 37 J. LEGAL EDUC. 352, 355 (1987).
12. *See, e.g., id.* at 363 (predicting that clinical education in the future will rely less heavily on the internal "law office" model, and more heavily on less costly externships and simulated lawyering process courses); Condlin, *"Tastes Great, Less Filling": The Law School Clinic and Political Critique*, 36 J. LEGAL EDUC. 45, 66-70 (1986) (contending that externship clinics are not only less costly but are also preferable because of the inherent conflict in the in-house clinician's roles as both supervisor and evaluator).

also suggested that the increasingly conservative bent of law students would spell the doom of law clinics with their liberal, service orientation.

The Report debunks the myth of a decline in student demand for clinical instruction. Only eighteen percent of the responding schools reported a decrease in student demand for clinical education during the preceding two years.[13] Almost eighty percent of the respondents, in contrast, indicated no fall-off in demand, with approximately one-third of the schools reporting a demand increase.[14]

The survey results also indicate that the demand for clinical education varies significantly with the size and diversity of a law school's clinical program. Schools with only one or two clinical offerings were the most likely to have either a stable or declining enrollment.[15] On the other hand, schools with more than two clinics were the most likely to have gained in enrollment.[16] When viewed in conjunction with the overall increase in demand, this dichotomy suggests that student demand for clinical education itself is quite high, but varies with student interest in the subject matter of the particular clinical offerings. In other words, student demand reflects the extent to which a law school is willing to invest in a diversity of clinical opportunities.

The experience at the University of Minnesota Law School is consistent with the findings of the Report. During the 1986-87 school year, a total of 192 students enrolled in six in-house, live-client clinics.[17] By the 1988-89 school year, these figures grew to 217 students in seven clinics, an enrollment increase of thirteen percent. Moreover, this growth occurred at the same time that externships and simulated pre-trial courses were also

13. *See* THE REPORT, *supra* note 2, § II, at 17. It should be noted that this conclusion is not based on the most desirable statistical data. The survey did not ask the law schools to provide actual enrollment figures for clinical courses. The survey, instead, simply asked respondents the following question: "Within the last two years, has demand for live-client clinics at your school increased, remained constant [or] decreased." *See id.* app. 1, at 3. Nonetheless, the lopsided response to this question, with less than 20% of the answering schools reporting a decline, appears to provide sufficient support for the Report's conclusion that student demand for clinical education has not declined.

14. *See* THE REPORT, *supra* note 2, § II, at 17-18.

15. *See id.* § II, at 19-20.

16. *Id.*

17. The author prepared the enrollment data for the University of Minnesota Law Clinics as part of a "Report on Clinical Programs" that was submitted to Dean Robert A. Stein on October 25, 1989 (on file with author).

expanding. Viewed together, the Minnesota study shows a nineteen percent overall enrollment growth in professional skills courses.[18]

The 1980s was not the first time that the death knell has been sounded for clinical education. From its inception in the 1960s, some writers have discounted clinical education as a temporary fad whose time would soon pass. Some criticized clinical education as too service oriented and not sufficiently rigorous in its pedagogical methods.[19] Much of this criticism was accurate and led to positive changes in the clinical curriculum.[20] Like the announcement of Mark Twain's death, however, the much-rumored demise of clinical education has remained premature.

Perhaps the principal impact of the Report is to make the alleged decline in clinical education a nonissue and to remove it from the 1990s agenda. In spite of many obstacles, live-client clinical education is not only alive, but growing. Coupled with simulated courses and externships, student demand for lawyering skills instruction is greater than ever. This demand, in turn, corresponds with continuing pressure from the practicing bar and the American Bar Association for law schools to take steps to enhance lawyering competency.[21] The time has come for the American legal education system to cease arguing about whether clinical education has any role to play and to refocus attention on what that role should be.

B. PEDAGOGICAL GOALS

Clinical teachers have long had a difficult time in articulating the educational objectives of clinical education. This inability does not mean that clinicians doubt the educational

18. The size of the clinical faculty during this period remained constant.

19. *See, e.g.*, Tomain & Solimine, *Skills Skepticism in the Postclinic World*, 40 J. LEGAL EDUC. 307, 314-15 (1990); Allen, *The New Anti-Intellectualism in American Legal Education*, 28 MERCER L. REV. 447, 456-57 (1977).

20. For example, most law schools have improved the educational quality of their clinical programs by adding classroom sessions that facilitate lawyering skills instruction. The Report indicates that 89% of clinical programs now include a classroom component. *See* THE REPORT, *supra* note 2, § II, at 36.

21. *See, e.g.*, ABA SECTION OF LEGAL EDUCATION AND ADMISSIONS TO THE BAR, REPORT AND RECOMMENDATIONS OF THE TASK FORCE ON LAWYER COMPETENCY: THE ROLE OF THE LAW SCHOOLS 9-10 (1979). A recent survey of practicing lawyers revealed a widely-held belief that law schools fail to teach many of the professional skills that are most important to successful law practice. Zemans & Rosenblum, *Preparation for the Practice of Law — The Views of the Practicing Bar*, 1980 AM. B. FOUND. RES. J. 1, 5-6 (1980).

significance of their programs. On the contrary, clinicians strongly believe in the clinic's educational role. They just have difficulty in pinpointing exactly what that role is or ought to be.[22]

The Report attempts to rectify this problem by identifying nine goals of live-client clinical education.[23] Eight of these goals relate to the clinic's paramount education mission.[24] The remaining goal reflects the public service component of clinical education. The lower ranking of this service goal,[25] at the number seven position, puts to rest the old service versus education debate[26]

Although the Report does a laudable job of summarizing and synthesizing the various justifications for the clinical method, it suffers from the traditional clinical inferiority complex. By listing nine objectives, the Report both overstates and understates the case for clinical education. The list of nine goals overstates the case by suggesting that the clinic actually accomplishes all nine goals for all students. It does not. The actual impact of the live-client clinical experience inevitably depends upon the often uncontrollable nature of real cases. The Report also understates the case by stretching to list as many goals as possible rather than focusing on the unique contribution of the clinical method in legal education. Unfortunately, the laundry list of nine goals seems more a justification for the continued existence of clinical education than an articulation of pedagogical objectives.

A fundamental problem exists with attempting to define clinical education in terms of its pedagogical goals. The problem is that clinical education is not an amalgamation of goals,

22. Many scholars have attempted to define the educational goals of clinical education. *See, e.g.*, Amsterdam, *Clinical Legal Education — A 21st Century Perspective*, 34 J. LEGAL EDUC. 612, 616-17 (1984); Barnhizer, *Clinical Education at the Crossroads: The Need For Direction*, 1977 B.Y.U. L. REV. 1025, 1029-34; Spiegel, *Theory and Practice in Legal Education: An Essay on Clinical Education*, 34 UCLA L. REV. 577, 600-03 (1987).

23. THE REPORT, *supra* note 2, § I.

24. The eight educational goals described in the Report are: 1) developing modes of planning and analysis; 2) providing professional skills instruction; 3) teaching means of learning from experience; 4) instructing students in professional responsibility; 5) exposing students to the demands of acting in role; 6) providing opportunities for collaborative learning; 8) providing a context for the examination of particular doctrinal areas of the law; and 9) critiquing lawyers and the legal system. *Id.* § I.

25. THE REPORT, *supra* note 2, § I, at 9-10.

26. *See, e.g.*, Johnson, *Education Versus Service: Three Variations on the Theme*, in CLINICAL EDUCATION FOR THE LAW STUDENT 414 (1973).

but a distinct pedagogical *method*.[27] Live-client clinical education makes a unique contribution to legal education by introducing that otherwise missing ingredient — the client.[28] The law clinic provides a format for exploring the role that lawyers play in attempting to resolve legal problems in the service of their clients. The clinic, then, is a pedagogical method that allows legal educators to examine the dynamics of the lawyer-client relationship from within the relationship itself.

As a pedagogical method, clinical education does not have a predetermined, inherent set of goals. Instead, the clinic offers a format from which instructors may select from a number of possible goals. In the future, legal educators ought to view clinical education as a pedagogical method that is capable of facilitating a great many potential educational objectives. The Report makes an important contribution by providing a thoughtful list of possibilities. It is unrealistic, however, to expect any one clinic to accomplish all or even most of these possible goals. A successful clinical program will focus its energy on a narrower set of attainable objectives. A major agenda item for the 1990s will be to refine the Report's list of potential goals and to identify those best suited to the clinical method.

C. FINANCING THE CLINIC

Monetary issues loom large on the clinical agenda. Clinicians responding to the data collection subcommittee's survey cited the lack of monetary support as the major challenge facing clinical education.[29] Clinicians also listed the instability of clinical funding as the third most common problem.[30] As a solution, the Report recommends a concerted effort to obtain increased support through federal grants.[31]

The cost of financing clinical education is, indeed, a signifi-

27. Commentators often miss this point. For example, Dean Tomain and Professor Solimine, in a recent article, argue that skills training must embrace a normative theory of lawyering in order to be justified as a law school enterprise. *See* Tomain & Solimine, *supra* note 19, at 316-17. This makes little sense, however, once clinical education is recognized as a pedagogical method as opposed to a pedagogical goal. It is similar to suggesting that the socratic method or a class lecture format should survive only if tied to a particular philosophy of lawyering.

28. The role of the client in clinical legal education, accordingly, is similar to that of the patient in the medical school internship or the pupil in practice teaching.

29. *See* THE REPORT, *supra* note 2, § II, at 13.

30. *See id.*

31. *See id.* § V, at 1.

cant problem. This problem is related, in part, to the increased tightening of law school budgets over the past decade. In addition, the in-house, live-client clinic, with its relatively low teacher/student ratio,[32] is a more expensive teaching method than large lecture classes. Some law school administrators advocate simulated skills courses and externship placements as cheaper alternatives to the in-house clinic.[33] Taken together, the monetary squeeze certainly inhibits growth in clinical education.[34]

The Report takes a wrong turn, however, in looking to federal grant funding as the answer. Grant money is inherently unpredictable. The pot of funds goes up and down with changes in administrations and political trade-offs. A heavy reliance on grant funding makes programs precarious and long-range planning impossible.

A second problem with grant funding is the potential clash between curricular priorities and program survival. Educational goals and funding goals are not always consistent. Grant writers know that certain types of legal service proposals are more likely to receive funding than others. An addiction to grant funding may tempt clinic directors to design programs to achieve funding rather than educational objectives.

Perhaps most importantly, the continued reliance on grant funding may inhibit a permanent law school commitment to clinical education. All too often, the end of the grant means the end of the clinic that it funded. Moreover, the lack of permanency associated with grant funding virtually necessitates a second-class status for both the program and the clinicians that teach in that program. Law schools are unlikely to include these "temporary" clinicians into the mainstream of academic or institutional life. The data collection section of the Report, for example, indicates that none of the responding clinicians funded on soft money viewed themselves as having full faculty status.[35]

Although grants provide great opportunities for start-up funding or short-term needs, permanent law school funding

32. *See id.* § II, at 27 (survey results illustrate a typical teacher/student ratio in the range of 1:8 and 1:10). *See also* LaFrance, *supra* note 11, at 355 (describing an overall law school ratio of 1:25 or more).

33. *See* LaFrance, *supra* note 11, at 357.

34. *See* Allen, *supra* note 19, at 457.

35. *See* THE REPORT, *supra* note 2, § II, at 28. In contrast, all tenured clinicians and 22% of the non-tenured but law school-funded clinicians viewed themselves as possessing full faculty status. *Id.*

must be the goal. Unless clinical programs are financed like the other components of legal education, they will remain tangential to the core law school mission.

This goal, of course, is easier to state than to accomplish. Most clinicians desire permanent law school funding but resort to grants as the next best alternative. Most law schools would devote more resources to clinical education if more resources were available. The real issue for the clinical agenda, then, is not so much the appropriate source of funding, but how to obtain (or maintain) a permanent base of law school financial support.

Many law schools, like Minnesota,[36] have succeeded over the past decade in establishing a permanent funding base for their clinical programs. The crucial prerequisite appears to be the support of the law school administration and faculty. Although no magic formula exists for accomplishing this task, two factors are probably mandatory. First, nothing succeeds like success. A high quality clinical program with a well-defined educational focus is an essential first step. Second, the law clinics must become integrated, at least to a substantial degree, with the other segments of the law school community.

A corollary issue on the clinical agenda will be how to enhance clinical programs within continuing budgetary constraints. Even at schools with strong institutional support for clinical programs, substantial increases in funding in the near future is unlikely. Thus, any short-term growth in clinical programs will depend more on creativity than on large infusions of financial support.

At Minnesota, for example, the Law Clinics substantially increased enrollment over the past three years while the size of the clinic faculty remained the same. Between 1986 and 1989, enrollment in live-client clinics increased by thirteen percent, and overall clinic enrollment in lawyering skills courses increased by nineteen percent.[37] The Law Clinics managed to keep pace with rising student demand through a variety of methods. One such method involved creative program development. For example, the Clinic faculty created specialty subject

36. The University of Minnesota Law Clinics are primarily funded by the law school itself. All 5.5 permanent clinical faculty positions are on hard law school money. The Minnesota State Public Defender's Office funds two additional adjunct positions, and a Department of Education grant will fund a temporary position beginning in January 1991. This strong institutional support reflects the commitment of Dean Robert A. Stein and the law school faculty.

37. *See supra* note 17 and accompanying text.

matter clinics that build upon specific substantive course offerings,[38] carefully structured externship programs that include in-house class sessions and shared case supervision responsibilities,[39] and a pre-trial lawyering skills simulation course.[40] The Law Clinics also expanded their instructional capacity by encouraging joint teaching efforts with nonclinic faculty,[41] and through the use of upper-class student directors as teaching assistants.[42]

Financing the clinic will continue to be a major issue on the 1990s agenda. The increased federal funding recommended by the Report is an important means to engender innovation and to demonstrate the capabilities of clinical education. The long-term success of clinical education, however, requires both

38. The Workers Compensation/Social Security Disability Clinic (Professor Kathryn Sedo) and the Immigration Clinic (Professor Anna Shavers) illustrate this approach. Both clinics require students to first take the corresponding substantive law course before enrolling in the clinical component. Since the students are already familiar with the doctrinal law, a higher student/faculty ratio is possible in these clinics.

39. Both the Domestic Abuse Clinic (Professor Beverly Balos) and the Public Interest Law Clinic (Professor Stephen Befort and Adjunct Professor Theresa Murray Hughes) are based on this model. The Public Interest Law Clinic, for example, has weekly class sessions taught by the clinical faculty. Students then work with attorneys in the community on impact litigation or legislative projects that comply with pre-designed educational criteria. The clinic faculty also review drafts of the student's written work product and make suggestions for improvement.

40. The Lawyering Process course (Professor Maury Landsman) is an important addition to the curriculum because it provides a format for the in-depth examination of basic lawyering skills such as interviewing, negotiation and discovery practice. Because this is a simulation-based course, a higher student/faculty ratio is possible as compared to live-client clinics. However, as the Report notes, simulation courses such as this should be seen as a complement to, rather than a substitute for, live-client clinical courses. *See* THE REPORT, *supra* note 2, § I, at 5. Although simulation courses are excellent vehicles for lawyering skill instruction, they are less capable of replicating the dynamics of the lawyer/client relationship than clinics with real clients and real cases. *See* Brest, *A First Year Course in the "Lawyering Process,"* 32 J. LEGAL EDUC. 344, 351 (1982).

41. For example, the classroom portion of the new Gender and the Law Clinic (Professor Balos) is co-taught with Professor Mary Louise Fellows, a member of the nonclinic faculty, and the Public Interest Law Clinic is jointly taught by the author and Adjunct Professor Theresa Murray Hughes, the Executive Director of the Minnesota Justice Foundation.

42. Professors select student directors from among third-year law students who have completed one of the introductory clinic programs. The student directors handle the more difficult clinic cases, provide the initial review of student attorney work product, and participate in the management of the clinical program.

functional and financial integration with the other segments of the law school community.

D. FACULTY STATUS

Some issues never go out of style. The debate about the appropriate status for clinical faculty is a prime example.

Law schools originally hired most clinicians under short-term contracts not leading to tenure. Similarly, law schools restricted clinicians in participation on matters of faculty governance. Law schools justified this less-than-full status arrangement on numerous grounds, such as the questionable permanency of clinic faculty positions, the lack of classroom teaching responsibilities and, most of all, the absence of a requirement to engage in scholarship. Clinicians railed against this second-class treatment, since many of the substance of the reasons for the disparate status diminished.

The faculty status debate raged through most law schools during the past decade. In 1984, the American Bar Association addressed the issue when it adopted Accreditation Standard 405(e).[43] This standard states: "The law school should afford to full-time faculty members whose primary responsibilities are in its professional skills program a form of security of position reasonably similar to tenure and perquisites reasonably similar to those provided other full time faculty members . . . ."[44] Although falling short of calling for tenure for clinicians, Standard 405(e) does adopt a requirement of "reasonably similar" status.

The Report indicates that most clinicians see little positive impact on status resulting from the adoption of Standard 405(e).[45] Unfortunately, the Report does little in the way of verifying the accuracy of this perception because the data collection subcommittee did not collect statistical information concerning the current faculty status of clinical teachers.

Despite the Report's findings on the reaction to Standard 405(e), it is clear that the status of clinical faculty has improved considerably at many law schools. Data collected by the American Bar Association during 1986 and 1987 indicates that fifty-five percent of all professional-skills teachers occupied positions

43. AMERICAN BAR ASSOCIATION, POLICIES OF THE COUNCIL OF THE SECTION OF LEGAL EDUCATION AND ADMISSIONS TO THE BAR AND OF THE ACCREDITATION COMMITTEE, Standard 405(e) (1987).

44. *Id.*

45. *See* THE REPORT, *supra* note 2, § II, at 31-33.

eligible for tenure.[46] The Report survey results appear to confirm this trend, with seventy percent of the respondents describing either the same or similar promotion criteria for both clinical and nonclinical faculty.[47]

A patchwork pattern currently exists on the status debate. On one end of the spectrum, a growing number of law schools afford clinicians full faculty status on a unified track with other instructors. On the other extreme, many law schools still utilize the short-term contract approach. Numerous variations exist in between these models, including separate tenure-like (but not quite equal) tracks, and tenure-track clinical directors combined with short-term clinical associates.[48]

The principal obstacle to equivalent status is the traditional publication requirement for tenure. Clinicians point to large caseloads and longer school years[49] as inhibiting the necessary time for scholarship. In addition, law schools hired most clinicians because of their practice skills rather than their scholarly potential.[50] Many schools compromise by hiring clinicians on a separate professional track with somewhat less status and security than tenure in exchange for the elimination of the publication requirement.[51] This compromise is particularly

46. AMERICAN BAR ASSOCIATION, QUESTIONNAIRE CONCERNING STATUS OF PROFESSIONAL SKILLS TEACHERS (1986-87), *cited in* THE REPORT, *supra* note 2, § III, at 11. The "professional skills teachers" surveyed by the ABA include faculty teaching in simulated classroom courses as well as the traditionally lower status, in-house clinical instructors. Accordingly, the 55% figure probably overstates the percentage of tenure-track clinicians.

47. *See id.* § III, at 25. Thirty-six percent of the respondents described promotion criteria as the same for both groups. Another 34% reported similar standards, with alternatives in the applicable publication requirements cited as the most common adjustment. *Id.*

48. Variations in faculty status for clinicians are described in THE REPORT, *supra* note 2, § III, at 11-13.

49. The data collection section of the Report concludes that "even tenured clinical faculty average ten months of teaching rather than the nine expected of other faculty [while n]on-tenured clinic teachers are expected to teach even more, averaging about eleven months per year." *Id.* § II, at 26.

50. Clinicians responding to the survey listed practice skills as the major additional criteria for hiring clinical faculty as compared to nonclinical faculty. *See id.* § II, at 24.

51. The University of Minnesota, for example, has adopted this approach for all clinic faculty positions except the two tenure-track clinic directors. A thirteen-page document entitled "The Personnel Policies and Procedures for Clinic Faculty of the University of Minnesota Law School" provides for clinic faculty appointments in a separate Professional and Administrative track. The initial appointment includes a three-year probationary term with eligibility for a continuous appointment after 3-6 years of teaching. The University may ter-

attractive to higher-ranked institutions with a strong dedication to the goal of scholarly productivity.

The issue of faculty status will remain a major issue on the clinical agenda for the foreseeable future. For clinicians, in fact, faculty status is more a crusade than an issue. Nothing can raise the ire of clinical faculty more than the perception or reality of second-class status. More significantly, the status dichotomy both defines and reinforces the institutional segregation so inimical to the future of clinical education.

The ultimate solution is full equality with clinical faculty eligible for tenure on a unified faculty track. No other solution can accommodate the necessary integration of clinical education with the rest of the law school curriculum.

Many clinicians, however, will not like the equality that a unified faculty track brings. It will inevitably come with two significant trade-offs. First, clinicians aspiring to tenure will have to produce legal scholarship. The scholarship prerequisite cannot simply be dismissed as irrelevant or elitist. Clinicians cannot expect to achieve equality without also satisfying substantially equivalent criteria. This acknowledgement does not mean, however, that adjustments should not be made that reflect the unique environment of clinical teaching. Acceptable scholarship should not be so narrowly defined as to exclude the scholarly efforts for which clinicians are best-suited — an analysis of the lawyer/client relationship as viewed from the intersection of theory and practice. In addition, law schools must provide clinicians with sufficient time to engage in scholarship.[52]

A second trade-off is that many current clinicians may not survive the transition. Law faculties will undoubtedly adjust hiring criteria to reflect the enhanced clinical job description. Search committees will give more weight to scholarly potential and less weight to a background in legal services.

As the fairy godmother said, "be careful for what you wish, for it might come true." As difficult as these trade-offs may be for some, they are essential steps if clinical education is to flourish in the future.

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minate a continuous appointment only for cause, program elimination or financial exigency (on file with author).

52. The Report endorses both of these adjustments. *See* THE REPORT, *supra* note 2, § III at 13-15.

E. THE UPSTAIRS/DOWNSTAIRS PROBLEM

The Report's most significant conclusion is an unstated one — clinicians as a group feel very alienated from the rest of the law school faculty world. The upstairs nonclinical faculty get money, chairs and respect. The downstairs clinicians get overworked, underpaid and unappreciated.

The upstairs/downstairs problem is neither new nor startling.[53] The dichotomy and the accompanying resentment are as old as clinical education itself. It is troubling, however, that the problem is so strongly felt and resistant to change in spite of the gains otherwise made in the field of clinical education.

Evidence of the upstairs/downstairs problem reverberates throughout the Report. For example, the Report listed the lack of faculty support as the second most common challenge perceived by clinical educators.[54] Further, the school year for clinicians is up to two months longer than for nonclinical faculty,[55] and clinical courses are comparatively underaccredited.[56] Many clinicians believe that their schools provide inadequate space and litigation fund support for their programs,[57] and also see themselves "receiving less respect and, possibly, lower pay."[58] These findings, of course, are in addition to the funding and status concerns already discussed.

The Report's depiction of alienation reflects the more fundamental problem of clinical education's lack of integration into the lifeblood of the larger law school community at many institutions. Although clinicians complain about inequality and a lack of respect, nonclinicians complain that they do not know what the clinic is doing or how it relates to the rest of the curriculum.

The continued gulf between clinicians and nonclinicians is the most important item on the clinical agenda. Quite simply, the past history of segregation has stunted the development of

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53. *See* Allen, *supra* note 19, at 456.

54. *See* THE REPORT, *supra* note 2, § II, at 7.

55. *See id.* § II, at 26.

56. *See id.* § II, at 35-36. The data collection subcommittee concluded "that the average clinic student spends approximately one hour more per week per credit than his nonclinic compatriot." *Id.* § II, at 36.

57. *See id.* § II, at 13. Most clinicians did report, however, adequate overall infrastructure support from their schools. *Id.*

58. *Id.* § III, at 8. The data collection section of the Report states that the subcommittee lacked sufficient salary data to confirm or disprove the perception of lower pay for clinical educators. *See id.* § II, at 29.

the clinic. As in the public school system, separate is never quite equal. Integration is the key.

Like any other intra-family feud, the problem is how to facilitate communications in order to bridge the gap. The situation is certainly not hopeless. At many schools, integration has already taken place or is in progress. The Report clearly reveals, however, that the problem still widely persists.

Clinicians tend to believe that the problem of segregation is a responsibility of the nonclinical faculty to rectify. After all, the argument goes, the nonclinic faculty possess both the historically "incorrect" view and the institutional power to effect change. This perspective has some merit, but only up to a point. Clinicians, too, must accept responsibility for promoting greater integration. All too often, clinical teaching conferences deteriorate into endless sniping at the injustices of the "stand up" faculty. In addition, too many clinicians indulge in the "dropout phenomenon" and simply withdraw from interaction with the nonclinical faculty.

Integration requires interaction. Clinical and nonclinical faculties must exchange information and ideas. Clinicians must also participate in the life of the institution beyond the clinic offices. It may be difficult, but it is also essential.

Integration will undoubtedly come. Most members of the law school community already recognize that the clinic and the classroom are complementary rather than competing educational methods. Clinical education is a necessary component of any professional school education, legal or otherwise. Clinical education also provides a vital link to a practicing bar that is increasingly bewildered by the theoretical disdain that too many legal educators hold for the practice of law.[59] Further, law faculties themselves are reconsidering the traditional primacy of scholarship over professional education as the proper focus of their endeavors.[60] Yes, integration will come, but the effort must come from clinicians and nonclinicians alike.

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59. *See, e.g.*, Edwards, *The Role of Legal Education in Shaping the Profession*, 38 J. LEGAL EDUC. 285, 291 (1988) ("The gap between the academy and the profession seems to be growing. Law professors seem more and more often content to talk only to each other — or perhaps to a few colleagues in other academic disciplines — rather than deal with the problems facing the profession.").

60. *See* Elson, *The Case Against Legal Scholarship or, If the Professor Must Publish, Must the Profession Perish?*, 39 J. LEGAL EDUC. 343, 345-54 (1989).

CONCLUSION

The clinical agenda for the 1990s will, after all, not be very different from the agenda of the past decade in its substance. Concerns with pedagogical goals, funding, faculty status and curricular integration will continue to predominate. The significance of the Report is to provide an improved context for this agenda, one that sharpens the focus of the debate by affording a comprehensive portrayal of the current state of in-house, live-client clinical legal education. Despite the Report's shortcomings, this contribution is very important.