

DEVELOPING A TEACHER TRAINING PROGRAM FOR NEW CLINICAL TEACHERS

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Where to Begin? Training New Teachers in the Art of Clinical Pedagogy, an article published in the Spring, 2012, issue of the *CLINICAL LAW REVIEW*, gave a full description of Georgetown's course in clinical pedagogy. That article set forth some of the critical questions new teachers must ask and answer by describing the goals, content, and execution of the course.

This article describes hows, whens, and whys of the program, focusing on how our faculty, over a period of many years, created and revised the curriculum for the Pedagogy course. It also describes the choices we made as we developed the course. Although it may be of interest to all clinical teachers, this article's main audience is more experienced teachers within a region whose schools regularly meet to discuss issues relating to clinical pedagogy, clinic directors at schools that hire several clinical teachers in a short period of time, and teachers who wish to develop a teacher training program for new clinical teachers. The two articles, when read together, will give those teachers and directors an understanding of the choices we made in developing the teacher-training program at our school and provide an outline to use when developing similar programs tailored to meet the needs of their own schools and faculties.

I. INTRODUCTION

Georgetown Law School is the home to one of the country's largest and most extensive clinical programs. We have eighteen full-time clinical faculty members, many of whom are first generation clinicians who learned their craft on the job.² The faculty is supplemented by

¹ Wallace Mlyniec is the Lupo-Ricci Professor of Clinical Studies and former Associate Dean for Clinical Education at Georgetown Law Center. As with the first article, my research assistants, Katie Kronick and Alex Berg, researched and assisted in editing portions of several sections of the article. Jane Aiken, Deborah Epstein, Paul Holland, Kris Henning and Ben Barton read early drafts of the paper and made significant contributions to its success. Anna Selden and Abby Yochelson provided editing support. I am grateful for their support and their contributions.

² All clinical faculty members are hired on an integrated tenure track and have full parity with non-clinical teachers. Most early clinical teachers learned their techniques on the job. Paul Bergman, Professor of Law at U.C.L.A. Law School, while speaking about early clinical pedagogy, once candidly admitted that, "we made it up as we went along!"

between twenty-six to thirty graduate clinical fellows who obtain an LL.M. degree in Advocacy, and assist the faculty as we teach three hundred J.D. students each year in fourteen clinics offering twenty-three clinical courses. We also teach an additional three hundred and sixty students in thirty practicum courses that other schools would probably call clinics.³

Each year, between twelve and fifteen of the clinical fellows begin the two-year LL.M. program. Several come to Georgetown after having been public interest lawyers. Others come straight from law school or judicial clerkships. Almost all have taken a clinical course while in law school. Most of the fellows come for one of two reasons. They come to enhance their public interest lawyering skills or they seek to begin a career as a clinical teacher. Some will become public interest lawyers immediately after the fellowship but will enter the academic world later in their careers.⁴

The size and scope of our fellowship program presents unique challenges. The fellows come to Georgetown to learn (as they earn their degrees), but they also serve as clinical teachers while they are with us. In an effort to accommodate the dual roles of student and teacher, our fellows take a custom-designed course in clinical pedagogy that initiates them into the academy of clinical teachers.

In an article entitled *Where to Begin? Training New Teachers in the Art of Clinical Pedagogy*,⁵ published in the Spring, 2012, issue of the CLINICAL LAW REVIEW, I gave a full description of our course in clinical pedagogy. That article set forth some of the critical questions new teachers must ask and answer by describing the goals, content, and execution of the course. New clinical teachers were the primary audience for the article, but it was also useful to more experienced teachers who wanted to reconsider their teaching and supervisory methods or to create their own teacher training-program.

This article describes hows, whens, and whys of the program, focusing on how our faculty, over a period of many years, created and

AN ORAL HISTORY OF CLINICAL EDUCATION, PART ONE: SEEDS OF CHANGE (2006) [hereinafter ORAL HISTORY].

³ Only in-house programs taught by full-time faculty are called clinics at Georgetown. The practicum courses are not called clinics because they use either a hybrid model of clinical education or are supervised by non-full-time faculty. They also award fewer credits and require fewer hours of student work to fulfill the requirements. Finally, the students' legal work generally occurs outside of the Law Center. In pedagogical terms, they are situated in between externships and in-house clinics.

⁴ As of 2011, at least 120 former fellows were on the faculties of more than 70 different law schools. Many have become directors or associate deans of clinical education and a few have become law school deans.

⁵ Wallace J. Mlyniec, *Where to Begin? Training New Teachers in the Art of Clinical Pedagogy*, 18 CLINICAL L. REV. 505 (2012).

revised the curriculum for the Pedagogy course. It also describes the choices we made as we developed the course. Although it may be of interest to all clinical teachers, this article's main audience is more experienced teachers within a region whose schools regularly meet to discuss issues relating to clinical pedagogy, clinic directors at schools that hire several clinical teachers in a short period of time, and teachers who wish to develop a teacher training program for new clinical teachers. The two articles, when read together, will give those teachers and directors an understanding of the choices we made in developing the teacher-training program at our school and provide an outline to use when developing similar programs tailored to meet the needs of their own schools and faculties.

II. DEVELOPING THE PROGRAM

A. *The Early Years*

The antecedents to Georgetown's extensive clinical program can be traced to the creation of the E. Barrett Prettyman Fellowship Program in 1960,⁶ and the creation of the Law Center's first law student clinic in 1968.⁷ The original mission of the Prettyman Fellowship was to train recent law graduates to become public defenders, not clinical teachers. Adjunct professors and a few members of the classroom faculty, most notably, William Greenhalgh,⁸ originally taught the J.D. clinics at Georgetown. The Prettyman program and the clinics quickly evolved, however, and in 1972, fellows began to teach and supervise J.D. students in the Criminal and Juvenile Justice Clinics⁹ and in the Institute for Public Representation.¹⁰ Non-tenure track clinical faculty were also being hired at the same time.¹¹ Additional fellowships were established as new clinical courses were created.¹²

⁶ The original name of the Fellowship was the E. Barrett Prettyman Internship Program.

⁷ See Wallace J. Mlyniec, *The Intersection of Three Visions: Ken Pye, Bill Pincus, and Bill Greenhalgh—And the Development of Clinical Teaching Fellowships*, 64 TENN. L. REV. 963, 969 (1997).

⁸ Id., See also John Kramer, Wallace J. Mlyniec, and Greta Van Susteren, *In Memoriam: William W. Greenhalgh*, 31 A. C. L. R. 999 (1994).

⁹ Developing future public defenders remains one of the goals of the program. The fellows now help supervise J.D. students in the Criminal Justice, Criminal Defense and Prisoner Advocacy, and Juvenile Justice Clinics. For further information, see *Prettyman/Stiller Post-Graduate Fellowship Program*, GEORGETOWN UNIVERSITY LAW CENTER (April 12, 2011), <http://www.law.georgetown.edu/clinics/cjc/prettyman.html>.

¹⁰ In its earlier years, the Institute for Public Representation (IPR) was known as the Institute for Public Interest Representation, or "INSPIRE" for short. It was founded as a separate clinic and fellowship program in 1971.

¹¹ Georgetown created an integrated tenure track for clinical and non-clinical faculty members in 1995.

¹² All clinics at Georgetown now offer graduate fellowship positions. See Georgetown

Beginning in 1972, when the Prettyman fellows were integrated into the clinical program as supervisors for the J.D. students, Bill Greenhalgh taught a summer course designed to prepare the fellows for their teaching and supervision duties.¹³ This was our very first introductory teacher-training course for our fellows. Over time, fellows from the other Georgetown clinics occasionally attended the sessions.¹⁴

Although Greenhalgh's efforts were good for their time and purpose, they were naturally limited in scope. He taught only the skills needed in trial clinics and dwelled on criminal practice, as that was his specialty. He did not explore teaching and supervision issues in depth and his course suffered from a lack of developed material on clinical pedagogy. Of course in 1972, few of the methods we now use to critique, supervise, and teach had been created.¹⁵ Critique was usually directed at skills and feedback was generally limited to discussing the actions students had performed or were about to perform in a case. Consequently, Greenhalgh did not address the methods or the difficulties of teaching values and ethics that were unrelated to the Rules of Professional Conduct. Race and culture were acknowledged as a part of the criminal justice system, but were not explored in ways that permitted students to understand the pervasiveness of race and poverty in almost all aspects of American society. Although students were expected to reflect on their performances, there was no attempt to teach reflection as the foundation of academic and professional growth. Indeed, the course addressed few of the many issues that we now explore daily in modern clinical pedagogy.

Instead, Greenhalgh's course was designed to teach fellows how to move the case along, make sure students were prepared for their hearings, and deal with the substantive and procedural issues that arose in a typical urban criminal practice. It taught a method of critique, but it was more directive than reflective. In sum, the course did little to improve the fellow's understanding of emerging clinical pedagogy as we understand it today or to advance the notion of reflective life-long learning.¹⁶ After Greenhalgh died in 1994, his successors

University Law Center, *Clinical Graduate Fellowships*, available at, <http://www.law.georgetown.edu/clinics/fellowships.html> (last visited (April 13, 2012)).

¹³ Prettyman fellows, unlike other Georgetown fellows, do very little supervision in their first year.

¹⁴ Because no other clinic involved criminal law, most of the clinical faculty did not send their fellows to Greenhalgh's teacher-training sessions.

¹⁵ The first Clinical Teaching Workshop was held at Cleveland State University Law School in October of 1977. The first Clinical Teaching Conference was held at Georgetown Law Center in July of 1978.

¹⁶ These passages should not be read as criticism of Bill Greenhalgh. Bill was a pioneer in clinical education but also a man of his time. He had a clear goal for his program. He

at the Prettyman program continued to teach the course, but few fellows from our other clinics participated since it was focused primarily on supervising students in a criminal clinic.

B. Critiques

During my term as Associate Dean,¹⁷ I began to hear several criticisms about our fellowship program from other teachers and from the fellows themselves. We decided to consider revamping our fellowship program. At a 1995 clinical faculty retreat, we asked the fellows to meet without the faculty and prepare a list of the shortcomings they saw in the fellowship program, and to present their concerns to the faculty. The fellows had many suggestions for improving the program. Their main substantive critique, however, was about teaching and supervision. They felt that while they learned much about clinical teaching during their two-year tenure with us, they believed that they would have done a better job and would have felt more secure if a structured training program about clinical pedagogy had preceded or accompanied their actual supervision of students. This critique did not tell us anything we did not already know, but it did create the impetus for change.

A second critique, one arising both inside and outside of Georgetown, was that the fellows were too inexperienced to teach J.D. students and therefore, we should adopt a different model for our program. This critique suggested more than a reformation of the program, it suggested its elimination. The faculty evaluated this critique but chose to strengthen rather than abandon the fellowship model. While there are inherent weaknesses to a fellowship model, we felt (and still feel) that there is value in having recent law school graduates and other inexperienced teachers join our program as our fellows.¹⁸

wanted to create criminal lawyers who could navigate the hectic pace of an urban law practice and provide services to as many defendants as possible. As Bill often said, he wanted to teach his students and fellows to practice “tennis shoe” law, that is, to effectively represent as many defendants in as many courtrooms as possible.

¹⁷ I was either the Director or Associate Dean for Clinical Education from 1986 to 2005.

¹⁸ Because Georgetown established clinical education courses in the movement’s infancy, many of our faculty members are much older than their students and older than their fellows. The fellows, being closer in age to the students, help bridge some of the cultural differences between the faculty and students. See Minna Kotkin & Dean Hill Rivkin, *Reflections From Two Boomers*, 17 CLINICAL L. REV. 197 (2010) (illustrating the competing perspectives among the clinic faculty who started clinics and those of the newer faculty and the students); Praveen Kosuri, *X Marks the Spot*, 17 CLINICAL L. REV. 205 (2010) (describing how a Generation-X clinic faculty member sees law school clinics developing); Karla Mari McKanders, *Shades of Gray*, 17 CLINICAL L. REV. 223 (2010) (arguing that the newest clinicians, Millennials, cannot all be categorized in one manner and describing the difficulties in working with older clinicians); Stephen F. Reed, *A Self-Focused Self-Study of*

By using new teachers, we accomplish two goals. First, we are able to provide the foundational aspects of clinical pedagogy to a group of people who will help expand the methodology throughout the legal academy. Everyone must start somewhere. There are few venues other than the AALS Clinical Conferences where new teachers can improve their teaching and supervision ability.¹⁹ One of our jobs as senior teachers is to make sure that newcomers are trained for their current and future teaching and supervision duties as they gain clinical teaching experience. Second, we are able to economically satisfy student demand for clinical courses by staffing them with a core of experienced clinical teachers supplemented by a group of sufficiently trained new teachers. Doing so permits us to expand the number of J.D. clinic seats while retaining our commitment to a core tenure-track clinical faculty in each clinic.

C. Responses

After evaluating the criticisms and deciding to retain the fellowship model, we began to rethink the way in which we prepare new fellows for their teaching and supervision tasks. First, several teachers decided to reduce the J.D. students' caseloads and to slow down the pace of the cases and projects so that the fellows, as new teachers, could actually employ and reflect upon their teaching and supervision methods. We encouraged the faculty to increase their discussions about teaching with the fellows to ensure that a lack of experience did not result in poor supervisory choices.

Nonetheless, expecting inexperienced teachers to teach in a clinic without proper teacher training remained problematic. To remedy that shortcoming, we decided to create a structured teacher-training program. Envisioning a training program for new teachers coming from disparate backgrounds was not obvious. Many of the new fellows at Georgetown, like most new academics, have little experience in the craft of teaching. Some come to clinical teaching with varying degrees of law practice, training, and supervisory experience in public interest settings. Others come straight from law school and have experienced practice only in a clinic setting. Few have had any formal teaching experience. Both the absence of teaching experience and the existence of law office supervisory and training experience can mag-

Self, 17 CLINICAL L. REV. 243 (2010) (describing a Generation-X clinician's belief that clinics should be focused on skills development and only mildly encourage law reform and social justice).

¹⁹ Justine A. Dunlap & Peter A. Joy, *Reflection-in-Action: Designing New Clinical Teacher Training by Using Lessons Learned From New Clinicians*, 11 CLINICAL L. REV. 49 (2005).

nify the problems that new teachers face when they begin to supervise and teach J.D. students. Those coming straight from law school have witnessed the efforts of their own clinical teachers who were, in most cases, inspirational. The fellows' knowledge about the methodology behind that inspiration, however, is usually limited.²⁰ In some cases, their teacher's theoretical knowledge was equally limited. Thus, recent graduates have little upon which to base their new work and, correctly, may question their own competency to do the job.

Those who come from practice and are serious about clinical teaching as a career soon acknowledge that the transition from lawyer to clinical teacher is not easy, even if one was once training-supervisors in a legal aid or public defender office. They may find themselves unable to step back from the first chair, critique what they heretofore believed to be appropriate lawyering and training techniques, or appreciate that clinical teaching is not just about practicing law, mastering certain skills, achieving client goals, and feeling good when students win. The reflective appraisal of a student's work, the hallmark of clinical teaching, and the academic inquiry into the larger issues surrounding the practice of law, are far different from the work of a training or section supervisor.²¹ Thus, experienced lawyers em-

²⁰ Students in clinical programs seldom study the history or theory behind clinical pedagogy. Indeed, many faculty members, especially those who come straight from practice, are similarly unfamiliar with either.

²¹ Todd Edelman, former training director at the District of Columbia Public Defender and a former Visiting Professor of Law at Georgetown, described the differences this way:

The way I look at it, the goals of a criminal clinic supervisor are to teach the students some things about the role of a lawyer, trial practice, relationships with clients, the substantive law, and ethics, to provide a public service, and to help students determine their suitability for this kind of work. Those goals control, at least in a rough way, the model of supervision. For the most part, the students do not view the work of the clinic as their life's work, and a good portion of my supervision (not only at the beginning of the year, but throughout the academic year) consisted of motivating the students by focusing them on the mission and importance of the work and on the academic mission of the clinic. While the goal of the clinic was to teach by allowing the students to do as much as possible on the case, there was always an understanding that the supervisor was ultimately responsible for each case and client. Finally, because the point of the clinic is to provide an outstanding academic experience, caseloads are kept low, and reflections on (and even criticisms of) the models of representation are encouraged.

In a public defender or legal services office, the ultimate goal of the supervisor is to provide new attorneys the tools to succeed on their own. Given the large caseloads of line attorneys and the heavy responsibilities of the supervisors, as well as the fact that the cases are the responsibility of the line attorney rather than the supervisor, the type of intensive supervision of every aspect of the case that should be the norm in a clinic cannot be and should not be the supervision model in a public defender or legal services office. While the supervision in a professional office is thus, less exhaustive and intensive, it is aimed at improving higher-tiered skills. There is less space and need for discussions of the overall value and ethics of the work. The supervision focuses on broad questions concerning strategy and case theory, on fine-

barking on a teaching career may be hampered by their experience.

D. The New Program

With these thoughts in mind, a group of faculty members set about creating a teacher-training program for new fellows.²² Our first goal was to determine what skills and what knowledge new teachers needed to begin their work in the clinic. We also wanted to devise a program of instruction that would teach the new fellows how to design a clinical class and select materials, and how to develop the teaching and supervision techniques needed to help students expand their knowledge, represent clients, and develop habits of lifelong learning.²³ We acknowledged that any program we devised would be based on how we were teaching at Georgetown²⁴ and that even a well thought-out program would necessarily only begin to convey the many choices that a teacher can make when designing a clinical class, structuring a supervision session, or engaging in one of the many other teaching moments that comprise the clinical education experience. Having articulated these goals, we began to select topics, materials, and classroom exercises that would enable us to attain them.

We had to make many choices concerning topics and materials for the Pedagogy course. The designers discussed the foundational principles of clinical teaching. We consulted old AALS program materials to determine what issues recurred with sufficient regularity to be considered foundational by other members of our profession.

tuning trial preparation, and on the use of advanced trial techniques. It does not focus on the day-to-day management or the preparation of the case. Nor does the supervision focus on the larger systemic and societal questions that arise in the case, or on the personal development of the lawyer.

²² The original group joining me to design the Clinical Pedagogy course included Professors Hope Babcock, Deborah Epstein, Chai Feldblum, and Jason Newman.

²³ When the training program began, we were not familiar with the theory of “backward design,” most prominently and helpfully explained by Grant Wiggins and Jay McTighe. Using backward design, one “begins with the end [of the class] in mind” and then determines which methods permit the teacher to reach the established objectives of the course. *See generally* GRANT P. WIGGINS & JAY MCTIGHE, *UNDERSTANDING BY DESIGN* (2d ed. 2005). It now informs many of our teaching initiatives and forms the basis for our thinking when we revise parts of the Pedagogy course.

²⁴ Clinical teachers elsewhere sometimes refer to the “Georgetown model” of clinical education. This concept has always been difficult to describe because, in its early days, it included an amalgam of different teaching and lawyering models. Most of our original clinics had high caseloads. Our early clinics also tended to be subject-matter-focused and as such, teaching substantive law took on a greater role in Georgetown clinics than it did in other law schools’ models. When we began, we were also very litigation oriented. The expansion of our program into other areas of law has now diminished the percentage of subject matter based clinics and the number that are litigation based. Moreover, we continue to evolve. Notwithstanding the evolution of our pedagogical approach, some of the early attributes continue to permeate some of our clinics.

We talked to new and experienced teachers and to current and former fellows. We looked inward to our own clinics to determine what we were trying to teach in each and what we wanted our fellows to accomplish as teachers.

At first, we did not believe that the materials and topics needed to be applicable to other schools' clinical programs, so we focused on those that appeared to complement the clinics that existed at Georgetown. We were also aware that the lack of uniformity in teaching styles in the various Georgetown clinics made creating a single fellows' teaching course complicated. The size of our faculty and the different paths each member had taken to becoming a clinical teacher resulted in a Georgetown program that was less united in methodology than that found in clinical programs at other schools.²⁵ Disagreements about methods sometimes became magnified as we tried to create a training program that could be useful to fellows teaching in clinics that employed methods as diverse as those in the Center for Applied Legal Studies, in which the student and faculty roles are negotiated and described in a learning contract;²⁶ in the Criminal, Juvenile, and Domestic Relations Clinics, which used the more traditional methods of clinical supervision that were taught at early clinical conferences;²⁷ in the Institute for Public Representation, which is based on a law firm model of supervision and training;²⁸ and at the Federal

²⁵ It is safe to say that prior to 1980, Georgetown had a group of clinical courses that called itself a program. Georgetown's clinics were born by happenstance and grew haphazardly. Like many early clinical programs in legal education, we had no plan. All of our clinics were founded with soft money. Thus, courses came and went with little thought to how they fit together or complemented an overall clinical program. In some cases, clinics losing soft-money competed with one another for hard money, creating strains rather than integration. After 1980, many of the revenue issues were resolved, financial competition lessened, and the Law Center itself began to see the value of a normalized clinical program that was integrated into the overall law school curriculum. The clinics and faculty members that survived began to coalesce into a single entity united in part by our separate status as contract faculty rather than tenure track faculty. Nonetheless, there was very little sharing of ideas about clinical teaching methods unless the faculty members were friends outside of work. There was no coherent structure to the programs until the late 1980s even though Bill Greenhalgh and John Kramer had solidified the position of clinical education at Georgetown by 1982. When I became Clinical Director in 1985, my goal was to expand and unify the clinical program.

²⁶ See generally Jane Aiken, David Koplow, Lisa Lerman, J.P. Ogilvy, & Philip Schrag, *The Learning Contract in Legal Education*, 44 MARYLAND L. REV. 1047 (1985) (describing the learning contract, a "document drawn up by the student in consultation with [an] instructor specifying what and how the student will learn in a given period of time," which the Center for Applied Legal Studies (CALS) clinic uses).

²⁷ See generally Peter Toll Hoffman, *The Stages of the Clinical Supervisory Relationship*, 4 ANTIOCH L.J. 301 (1986).

²⁸ See generally Minna Kotkin, *Reconsidering Role Assumption in Clinical Education*, 19 N.M. L. REV. 185 (1989) (suggesting that modeling is also useful when teaching in a clinic).

Legislative Clinic and the Harrison Policy Clinic, which seemed to fit into none of the other models because of their focus on law making rather than dispute resolution.

In time, the magnitude of our disagreements diminished and we were able to develop an outline of a training program that we believed would prepare fellows and other new teachers to begin the task of supervising and teaching clinic students. We found that we had enough common ground to develop a training program that met the needs of all of our fellows and faculty. We believed our Pedagogy course would help the fellows develop as new teachers and permit those headed towards a career in clinical teaching to deepen their understanding of the goals and methods of clinical education. We also discovered that the methods used in each of our clinics were not as different as we had originally supposed.

As the program evolved, we began to believe that the model used in all of our clinics encompassed a particular organized method of clinical pedagogy that we wanted to impart to our fellows through the *Elements of Clinical Pedagogy* course. That model embodies six truths. First, we believe that teaching in a clinic is different from and more expansive than training lawyers in a purely professional setting and different from teaching in a doctrinal course. Second, clinical teaching is goal driven and based on backward design. Third, faculty intervention is intentional and based on making choices that further a student's education. Fourth, clinical education should be based on "Justice" in the most expansive meaning of the word.²⁹ Fifth, client and student needs are equally important in a clinical program and neither need be sacrificed for the other. Finally, clinical teaching is personal and designed to accept students where they begin and to maximize their potential to learn.³⁰

III. GOALS

Designing any course requires goals and choices. Our goals for the course were to provide the skills and knowledge new teachers need to begin their work in the clinic and to further integrate our separate clinical fellowships into a unified Fellowship program. We knew

²⁹ Georgetown University is a Jesuit institution of higher learning. Jesuit teaching generally shows a preference for the poor and expects students to use contemplation in action for the betterment of humankind. This spirit imbues our clinical programs.

³⁰ In Jesuit education, formation refers to the process of educating the whole student—mind, body, and spirit—and to instill a passion for learning, reflection, service, and the greater good of humankind. Its objective is to assist in the fullest possible development of all the talents of each individual person as a member of the human community. *The Characteristics of Jesuit Education*, available at http://www.seattleu.edu/uploadedfiles/core/jesuit_education/characteristicsjesuiteducation.pdf (last visited April 15, 2012).

that we could not create master teachers in the short time the fellows attend Georgetown. We believed, however, that there is identifiable knowledge that all new teachers should have in order to begin their tasks. We believed that new teachers need to know how the clinical education method developed and was integrated into the legal academy so that they may navigate their own place in their law schools and in the greater academic community. They need to learn how to conduct a supervision session since it is the main methodology clinicians use to achieve a client's case or project goals, advance a student's learning goals, and accomplish the faculty's pedagogical goals.

We believed new teachers need to learn how to navigate issues like ethics, values, difference, and assumptions that permeate students' interactions with their clients, partners, teachers, and the various other players who are involved in a case or project. Although the concept of "reflective engagement"³¹ may seem intuitive, learning to employ systematic critique to develop transformative learning is not readily apparent. New teachers need to learn how to teach methods of reflection so that their students can learn from their experiences and become life-long learners. The new teachers also need to learn how to structure a classroom exercise so that students will remain engaged as the teachers impart the lessons to be learned. Few new teachers have learned in, let alone taught, classes where multiple teaching formats were used. Understanding which format best enhances learning is critical to engaging students in the learning process.

New teachers also need to learn how to teach through the difficult and seemingly intractable problems that arise as students adapt to the role of a lawyer. Assuming the role of a lawyer and the responsibility that such a role entails is a new and often daunting experience for students that may produce disorienting moments and unexpected and unsettling emotions and reactions which demand clear and supportive guidance. Finally, students cannot learn without honest and accurate assessments of their work. Schools demand that the faculty hold their students to precise levels of accountability. As a consequence, new teachers need to learn how to give good feedback and accurate evaluations and how to translate those evaluations into fair and understandable grades.

These goals and needs were then incorporated into specific classes where they would be explained, discussed, and challenged with exercises that would be demonstrated, practiced, and critiqued. The content of the course and teaching methods of the classes were de-

³¹ DONALD SCHOEN, *THE REFLECTIVE PRACTITIONER: HOW PROFESSIONALS THINK IN ACTION* (1983).

scribed in the previous issue of the *CLINICAL LAW REVIEW*.³² The remainder of this article will discuss the structural challenges and choices we made while developing the course and the classes.

IV. STRUCTURE AND CHOICES

Once we were clear about the goals, outcomes, and class topics for the Pedagogy course, we faced a series of structural choices that had to be resolved in order to achieve the goals we set for the course. We had to decide who would teach the course; when we would teach the course; what readings we would select for each class; what teaching methods we would use to teach each class; and how we would integrate all of the classes so that fellows would understand how the lessons learned in each class related to those that followed or came before. Since we also had a goal of integrating our fellows and faculty into a more collaborative group of teachers, we also had to create a learning environment where that collaboration and trust would be enhanced.

A. *Who will teach?*

All clinical teachers are busy people. Adding to their workload, even when there will be programmatic rewards in the end, has a cost. Nonetheless, once a school decides to have a teacher-training program, someone has to teach it. In deciding who should teach our Pedagogy course, we chose to use many members of the clinical faculty rather than just one or two. Although we recognized the importance of time demands, our choice to involve the entire faculty had less to do with time than it did with our goal of integration.

We chose to use as many teachers as we could for three reasons related to our original goals. First, doing so served to integrate fellows from each clinic into a single clinical program. Prior to 1980, Georgetown had a group of individual clinical courses that the faculty called a program. Georgetown's clinics, like the clinics in many other law schools, were born by happenstance and grew haphazardly. Each was a separate entity and the school had no plan for an integrated clinical program or for systematic and coordinated growth. Fellows in one clinic seldom mingled with the fellows in other clinics. Indeed, fellows whose offices were on the first floor of the law school often did not know the fellows who worked on the third floor.

Second, that same history and the architecture of our buildings³³

³² Wallace J. Mlyniec, *Where to Begin? Training New Teachers in the Art of Clinical Pedagogy*, 18 *CLINICAL L. REV.* 505 (2012).

³³ In the early years of our program, the clinics were scattered among several buildings. Integrating the clinical and non-clinical faculty required that the separate clinics be housed

made collaboration among the clinical faculty rare when we started the Pedagogy course. Even when clinic cases shared overlapping issues and interests, we seldom pooled our resources to achieve shared goals. Many of us lamented this isolation and thought that by having multiple teachers plan and teach each class session, we would begin to break down the barriers and integrate the faculty into a more coordinated clinical program.

The third reason for involving the entire faculty related to the pedagogy itself. We believed that the fellows would benefit from exposure to the diverse teaching styles of the faculty. If differences really did exist in the teaching methods of the various Georgetown faculty members, fellows could compare the differences and then use any of the teaching and supervision methods that appealed to them. There would be multiple benefits. The fellows, especially those who were intent on pursuing academic careers, would be exposed to multiple methods of approaching a problem. J.D. students could derive a collateral benefit since the fellows might be less likely than the seasoned faculty member to prescribe only one way to perform a lawyering task. The clinic program as a whole would benefit by bringing new techniques into the supervision pattern of the individual clinics.

We continue to staff the pedagogy course with many members of our clinical faculty. Each class has two co-teachers who lead the class. The overall coordinator of the Pedagogy course either teaches or participates in a supporting role in every class session. The coordinator also serves to connect materials and lessons from one class to another, highlighting how everything the fellows learn is related to the overall goals of the course and the work they will do.

We also include a second-year fellow in many of the class teaching teams. Their experiences as teachers and supervisors during their first year are often different from those of the clinical faculty members. Thus, they provide the new fellows with insights that are different from those of the faculty and surface fellow-student issues that the faculty sometimes do not see. As our clinical faculty ages, we sometimes forget what it is like to be “new.” The issues we see are not always consistent with the issues that new teachers actually face. Including a fellow on the teaching team also serves to remind the faculty that along with age, the issues of gender, race, and hierarchy are dynamic features in any clinical program that may affect each participant differently. The inclusion of second-year fellows in the teaching team

in the main law school building. Unfortunately, we had no strategic plan for space allocation at that time so the clinics moved into available space with little concern for programmatic integration. Even today, we occupy space on two separate floors, which impedes frequent contact among students and faculty from different clinics.

has added that perspective and has proved very valuable for most of the class sessions.

B. When to teach?

After we decided who would teach the course, we had to decide the optimal time to teach the various classes. For various administrative and budgetary reasons, the fellowships begin in either July or August before the fall law school term begins. As we contemplated when to teach the course, we recognized that new teachers have much to learn before they begin their new tasks. We also assumed that front-loading the classes before the J.D. students arrived would reduce the fellows' anxiety, provide stronger early supervision of J.D. students, and avoid class absenteeism when unanticipated court dates or clients' needs arise.

Nonetheless, we decided that the new fellows' other commitments precluded condensing the entire training program into the weeks prior to the arrival of the J.D. students.³⁴ More significantly, we felt that front-loading all of the information would make it less contextual and, therefore, too abstract and less useful for the fellows. Understanding context is critical to good supervision. The fellows' prior experiences, either as students in a clinic or as supervisors in a public defender or legal services program, would have been far different from carrying the responsibility for resolving pedagogical problems as clinical teachers. Further, exposing the fellows to all of the pedagogical materials and techniques in advance of their need to use them would place the learning out of context. Doing so would result in fellows learning solutions to problems they had yet to encounter as teachers. Presenting solutions to difficult and even routine issues in the abstract could not demonstrate the complexity of those problems.

For all of these reasons, we designed a two-day, shared learning orientation prior to the arrival of the J.D. students that provides the fellows with information about the history of clinical education and the role of clinical education at Georgetown, and exposes them to the typical supervisory practices they will encounter early in their work. We then developed classes to explore other more complex teaching and supervision issues that would be addressed in a series of sessions

³⁴ When the fellows arrive, they must attend to the many administrative tasks that all new employee face. In addition, they need to be integrated into an already developed clinic team, to learn the basic subject matter of the clinic and the procedures that guide it, and to familiarize themselves with the cases to which they will be assigned as lawyers and supervisors. Some clinics have their J.D. students come back before the regular semester begins so the fellows will also be getting to know their new students.

that would extend over the entire first year of the fellowship.³⁵

After the orientation, we take a break from the Pedagogy classes for a few weeks so that the fellows can begin to establish their relationships with their J.D. students. In late September, we begin the monthly, two-hour classes on topics that delve deeper into some of the more complex issues that we believe are critical to understanding the theory and practice of clinical pedagogy. Those classes concern additional supervisory and teaching techniques related to ethics, values, assumptions, race and other differences, collaboration, evaluation, grading, and classroom teaching. These formal classes are supplemented each month with informal lunch sessions. The content of the lunch sessions vary from unstructured discussions of the fellows' choosing to more formal presentations about employment possibilities, writing projects, and teaching issues that the fellows have encountered in their work. We often subject the fellows' supervision and teaching impasses to the case rounds format.³⁶ Other times, the fellows just have lunch and enjoy each other's company. Participation in the lunch sessions, unlike the actual classes, is voluntary but attendance is generally high.

In the last class of the first semester, the fellows are led through a reflection exercise concerning their work thus far that organizes their experiences into a structured understanding of the various problems they have encountered. We ask them to reflect on their best experiences, their worst experiences, the most surprising experiences, and the things they wish they had known before they started teaching. We relate those experiences to the materials, discussions, and teaching tools that were discussed earlier in the semester. Doing so reinforces the concept of scaffolding, that is, building on prior knowledge to master new material. It also reinforces two of clinical education's basic tenets, reflection and learning from experience.

After the mid-year break, the course resumes with one class per month throughout the second semester. We believe this overall course design provides for a dynamic rather than abstract training program that enhances the fellows' understanding of their role in our clinical program and their ability to fulfill their responsibilities. It also fosters collaborative learning and continues the fellows' integration into a unified program throughout the year.

³⁵ The complete syllabus for the orientation and the subsequent classes can be found in Mlyniec, *Where to Begin?*, *supra* note 5, at Appendix A.

³⁶ See Susan Bryant & Elliot S. Milstein, *Rounds: A "Signature Pedagogy" for Clinical Education?*, 14 CLINICAL L. REV. 195, 200-03 (2007) (explaining rounds as a process in which students discuss their cases and clients and consult with each other on the best ways to address issues).

C. *What readings will we assign?*

The amount of literature regarding clinical education is immense.³⁷ There are articles about lawyering, teaching methods, supervision techniques, grading, and a host of other topics related to teaching the reflective practice of law, the role of lawyers, and the place of lawyers in a democracy. New teachers need to understand the theory behind their work, but sorting through and choosing from the various articles and books is no small task for a new teacher.

We decided to begin the sorting by rereading much of the clinical canon. In developing the reading list for each class in the Pedagogy course, we selected both contemporary and older articles to convey the information that we thought clinical teachers need to understand as they start their careers. The readings expose the fellows to clinical theory, permit them to familiarize themselves with the vocabulary of our clinical theoreticians, and provide them with the substantive knowledge that underpins the methodology.

We have found that many of the more recent law journal articles about clinical education theory are highly sophisticated and require more than a working knowledge of clinical pedagogy to fully comprehend the authors' theses. As a result, they are not always helpful to new teachers. In rereading many of the articles in the canon, we found that some of the best articles for new teachers were actually written in the early years of clinical education when the pioneer clinical educators needed to formulate and articulate the basics of the emerging clinical pedagogy. All new teachers must be familiar with the basics before they begin to contemplate the more sophisticated aspects of the craft. The articles we select permit the fellows to learn the basics of our work. They also expose them to the more sophisticated aspects of clinical theory and method when they are ready.

There is probably no "correct" set of readings for a course such as this. The articles we originally chose and those we continue to choose are somewhat idiosyncratic. When multiple teachers begin to select their favorites on any topic, the choices are personal, generational, and gendered, as well as substantively informative. We use articles primarily from legal sources, but also some from the literature of educational theorists. Those we choose are either provocative or demonstrative of the information and methods we want to convey.³⁸ We limit the number of works we assign to a few for each class since the

³⁷ See J.P. Ogilvy & Karen Czapanskiy, *Clinical Legal Education: An Annotated Bibliography*, available at <http://faculty.cua.edu/ogilvy/Biblio05clr.htm> (last visited April 15, 2012) (an earlier version is available at 7 *Clinical L. Rev.* 1-4 (2001)).

³⁸ The list of the articles can be found in Mlyniec, *Where to Begin?*, *supra* note 5, at Appendix A.

fellows have many things to do and, like the faculty, often have little time to accomplish all of it. Moreover, the selected articles go to the heart of the subject matter of each class. We do recommend other articles and books for those who wish to explore further either during the course or later in their careers. We continue to revise the readings, adding some and eliminating others, but believe the ones we have chosen achieve the goals we have set for the course.

D. *What teaching methods will we use?*

Like most law school professors, clinicians employ traditional Socratic style lectures, discussions, and problem solving exercises in their seminars. Clinical teachers have also added simulations,³⁹ performance critique,⁴⁰ and case rounds to their classroom repertoire.⁴¹ Because law students, as adult learners, do not always respond to the typical methods of the academy, new teachers need to be aware of strategies that have proven to be effective for adult learners in other contexts and replicate them, when appropriate, in the law school classroom.⁴² Thus, we wanted the new teachers to be familiar with methods for planning and conducting lectures, rounds, seminars, problem solving classes, simulations, and performance evaluations, and to be able to perform traditional Socratic inquiries when they are appropriate.

When we first planned this course, we were not familiar with educational theorists and their strategies. Nonetheless, we knew from the writings of our clinical canon that we would have to minimize Socratic methods and employ methods more conducive to adult learning into the planning and execution of the classes in the Pedagogy course. Thus, we decided to minimize lectures about the various topics and chose to employ discussions, simulated teaching and supervision examples, small group analysis, case rounds, and critique of recorded performances in each class. As the course evolved, we came to know

³⁹ See, e.g., Paul S. Ferber, *Adult Learning Theory and Simulations – Designing Simulations to Educate Lawyers*, 9 CLINICAL L. REV. 417, 417-19 (2002) (explaining that many clinics put students through one to three weeks of simulation training prior to students engaging in actual clinic work).

⁴⁰ See generally Peter Toll Hoffman, *Clinical Course Design and the Supervisory Process*, 1982 ARIZ. ST. L.J. 277 (1982) (describing how performance critique can help the student improve her skills in the clinic, as it fully engages the student in her learning).

⁴¹ See generally Susan Bryant & Elliot S. Milstein, *Rounds: A “Signature Pedagogy” for Clinical Education?*, 14 CLINICAL L. REV. 195 (2007) (examining the effectiveness of case rounds at educating students in the clinical setting, why they are widely used throughout clinical programs, and how faculty can meaningfully be involved in case rounds).

⁴² See Nira Hativa, *Teaching Large Law School Classes*, 50 J. LEGAL EDUC. 95, 101 (2000).

the work of Stephen Brookfield,⁴³ Joseph Lowman,⁴⁴ and Grant Wiggins,⁴⁵ and our teaching plans and methods are now influenced by their insights. Today, we consciously model the teaching techniques we want the fellows to learn, using several different teaching methods in each class and using techniques that make the fellows responsible for their own learning. By consciously employing varying methods and by commenting on their use and utility at the end of each class, we reinforce the notion of choice and provide examples of how the use of multiple teaching strategies in the classroom components of our clinical courses will increase student engagement in the lessons we seek to convey.

V. CONCLUSION

In developing the Pedagogy course, we hoped that by the time the fellows had completed it, they would be well versed in the theory and methodology of clinical pedagogy, and that their supervision and teaching would be informed by that theory. We assumed that they would use these techniques in their supervisory and teaching roles, and thus, the training program would be instrumental in easing them into their work at a reasonably high level of performance. We expected that their ability to teach and supervise would also improve throughout the year. We also believed that by teaching the course throughout the entire first academic year, we would be able to monitor their development and intervene if their skill level required it.

We can see the results of our and their first year's work when judging the fellows' performances in their second year of the fellowship. The fellows' supervision responsibilities increase in their second year. In many ways, their work begins to appear indistinguishable from that of the faculty in most clinics. They are not, however, left on their own. They are aware of supervisory issues because of their first year training. They assist in the training of the new fellows and attend the lunches where supervision issues are discussed. They have access to their own clinical faculty at periodic staff meetings where supervision and case issues are explored, and to the Associate Dean with whom they discuss student and faculty problems before they erupt into much larger issues.

The second year fellows report that the class sessions and subsequent collaborations are extremely helpful to them in providing an

⁴³ STEPHEN D. BROOKFIELD, *THE SKILLFUL TEACHER: ON TECHNIQUE, TRUST, AND RESPONSIVENESS IN THE CLASSROOM* (2d. ed. 2006).

⁴⁴ JOSEPH LOWMAN, *MASTERING THE TECHNIQUES OF TEACHING* (2d. ed. 1995).

⁴⁵ GRANT P. WIGGINS & JAY MCTIGHE, *UNDERSTANDING BY DESIGN 206* (2d ed. 2005).

understanding of the tasks they are called on to perform, especially when the need for on-the-spot interventions occurs. The faculty report that their second year fellows are now better prepared to confront and resolve pedagogical and supervisory issues than were the fellows who came to Georgetown before the course was created. The year-end course reviews of the fellows submitted by their J.D. students are almost always positive. More importantly, the fellows have the trust of their students. After the first few days of the clinic semester, the J.D. students stop trying to validate the fellows' suggestions by testing them on the faculty. Fellows who have graduated and moved on to teaching positions in other schools describe the methods that they learned in the class as a significant part of their training that they continue to use in their later work.

Between our early efforts and today, the Pedagogy course has changed. We continue to discuss this course with professors from other schools, especially former fellows who are now teaching elsewhere, and make changes when appropriate. We are also able to test new ideas with more experienced teachers during Georgetown's Clinical Teachers Summer Institute. New classes and topics of discussion have been introduced, reading materials have been added and removed, and the organization of the classes has been changed. The faculty members who teach the course have developed new techniques and have become better teachers themselves. Certainly, no single course can possibly provide all one needs to be an accomplished, experienced, and successful teacher. There is always more to learn. Our Elements of Clinical Pedagogy course, however, serves as an introduction to what we believe are important topics for new teachers to consider as they encounter their first clinics and students.

After many years of planning, teaching, critiquing and revising the Pedagogy course, we are convinced it has been successful. The course appears to have achieved its goal of assisting the fellows as they make the transition to clinical teacher and supervisor. Further, our goals of increasing the integration of the various fellowships and of the faculty itself have been achieved. We also believe that the course could be useful to teachers at other law schools and is worth sharing with them. We hope that teachers who are planning to develop a training program for new teachers will be aided by our reflections as they develop their own courses.

