TAKING LAWYERING SKILLS TRAINING SERIOUSLY

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The lawyering skills so thoroughly explored in Gary Bellow and Bea Moulton's The Lawyering Process *continue to be a major focus of clinical legal education. Distinguishing between case-centered and skill-centered clinical programs, this essay explores whether clinical courses provide a sufficient foundation for students to "transfer" the lawyering skills they are exposed to in law school to the practice of law. Drawing on the recent work of educational researchers and medical school educators, the essay identifies structural attributes that enhance the likelihood of promoting lawyering skills "transfer." The essay argues that case-centered clinical programs tend to lack these attributes and identifies possible structural changes that can increase the likelihood that students will transfer lawyering skills learning from law school to practice.*

I. INTRODUCTION

Having embarked on clinical law teaching at the dawn of clinical education in 1970, we are delighted and honored to participate in this collection of essays spawned by *The Lawyering Process*.[1] The book helped to establish lawyering tasks such as interviewing, counseling and negotiation as complex and worthy of study in their own right. Bellow and Moulton's analysis demonstrated that carrying out such tasks effectively requires both analytical and inter-personal skills. By helping to create a substance for clinical legal education beyond client service, Bellow and Moulton helped to cement clinical education's

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[1] GARY BELLOW & BEA MOULTON, THE LAWYERING PROCESS: MATERIALS FOR CLINICAL INSTRUCTION IN ADVOCACY (1978) [hereinafter B & M].

place in law schools.

Part Two of *The Lawyering Process*, constituting by far the lion's share of the book, consists of chapters devoted to the lawyering tasks of Interviewing, Case Investigation, Negotiation, Trial Practice, Argument and Counseling. Thus, Part Two encouraged clinicians to take lawyering skills as seriously as non-clinical faculty took such subjects as Contracts, Torts and Property. Bellow and Moulton identify this goal specifically in the Introduction, where they state that they "believe that lawyer work can be analyzed and discussed in much the same way as a piece of literature or an appellate case."[2]

This essay argues that a widely-used approach to clinical legal education[3] that we call "case-centered"[4] neglects to treat lawyering skills with the kind of analytic rigor that Bellow and Moulton called for in *The Lawyering Process*. It may be that the seeds of this neglect are to be found in the book itself. For even as they called for in-depth examination of lawyering skills, Bellow and Moulton also provided sample course syllabi that suggested that a single course, meeting for four or even two hours per week for a semester, could adequately cover the lawyering tasks that Part Two explores.[5] Whatever the reason for the popularity of the case-centered approach, however, a substantial body of research into education and learning indicates that covering a wide variety of lawyering tasks in the same course is unlikely to significantly improve students' professional competence. Thus, the likelihood is that the case-centered approach to skills training shortchanges students' professional development.

Indeed, the case-centered approach to skills training may shortchange clinical education itself. Clinicians routinely lament the tendency of non-clinical law school faculty and administrators to perceive clinicians as "second class citizens." Yet the survey-type coverage to which the case-centered approach relegates lawyering skills may contribute to this unwelcome attitude. A survey approach tends to deni-

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[2] *Id.* at xxiii.

[3] We use the term "clinical legal education" in this essay to refer to law school courses and programs in which students represent actual clients under the supervision of law school faculty members. This essay does not address externship programs. Nor does it consider simulation-only clinical courses, though some clinicians may believe that for skills training purposes simulation-only courses are superior to live-client programs. Nor does it address substantive law courses taught through clinical methodology. For example, the essay does not speak to a Mergers and Acquisitions course in which students learn substantive law and drafting and negotiation skills by engaging in role play exercises related to mergers.

[4] *See infra* Section III. The case-centered approach is arguably the dominant one in the United States today. However, regardless of whether this is true as an empirical matter, it certainly is in widespread use.

[5] *See* B & M, *supra* note 1, at xix-xxii. The model for the two-hour-per-week course omits only "Witness Examination" and "Argument."

grate the significance and complexity of lawyering skills, much as a non-clinical instructor would shortchange first year "substantive" topics by offering a single course with the title "Contorterty."[6]

This essay elaborates on the deficiencies of the case-centered approach to skills training in clinical education and briefly evaluates the merits of existing and potential alternative approaches. However, we are neither so vain nor so confident in the merits of particular alternatives that we urge law schools to adopt any of them "as is." Moreover, we do not think it necessary or even desirable that all clinical courses adhere to a single approach, whether a case-centered one or any other approach that a clinician might champion.[7]

Rather, this essay represents an effort to place possible weaknesses in the case-centered approach to skills training on clinicians' radar screens. We will be satisfied if the essay stimulates clinicians and other interested legal academics to engage in conversations about the advantages and disadvantages of the case-centered approach and to consider possible alternatives. Such conversations should frankly acknowledge that tensions may exist between live client representation and effective skills training. We hope that clinicians will develop alternatives that take lawyering skills training as seriously as Bellow and Moulton suggested in *The Lawyering Process*.[8]

II. Two Overall Goals of Clinical Education

The case-centered approach to clinical education represents an effort to carry out the two primary but sometimes conflicting educational goals that have characterized clinical education since its origin in the late 1960's. One goal has been to improve students' professional skills, regardless of the clients they represent. William Pincus, who in his role as the head of CLEPR (the Council on Legal Education for Professional Responsibility) provided the seed money that en-

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[6] Possibly this is one reason that while clinical education is entrenched in law school curricula, it has tended to remain on the periphery. If clinicians regard their "substantive" topics such as interviewing and counseling as unworthy of in-depth treatment, why should "traditional" law professors think any differently?

[7] For example, the UCLA School of Law has a variety of clinical courses, some of which are in some aspects consistent with the case-centered approach and others much less so.

[8] Clinicians themselves often seem to deprecate a curriculum that focuses exclusively on skills. For example, a recent flurry of e-mails on the Clinical Listserve contained several comments such as: "However, I am often dismayed that 'we' have accepted the idea that we teach 'just skills;'" "I have never thought that we teach 'just skills;'" "OK, maybe I'm overly optimistic, but I think we can and do make a difference in more ways than just 'skills.'" (Portions of messages all posted on June 6, 2003; copies on file with authors.) We presume that clinicians who make such comments nevertheless want to teach skills effectively.

couraged many law schools to begin clinical education, identified this goal in these words:

> The first of the educational values, therefore, in clinical education which needs to be exploited is the teaching of standards for the performance of the basic skills involved in service to a client and a cause by a lawyer. By this we mean such skills as interviewing, collecting facts, counseling, writing certain basic documents including pleadings, preparing for trial, and conducting trial matters.[9]

A second common goal among clinicians, more overtly political, is to imbue in students the desire to devote their professional lives to legal and social reform. Again, Pincus clearly identified this goal:

> Clinical legal education should help to make the future lawyer sensitive to the broad issues going beyond the immediate case. It should give him practice in how to act as a lawyer in making constructive change in justice in the course of his professional work.[10]

Michael Meltsner's contribution to this Colloquium suggests that clinical education increasingly emphasizes the former of these goals.[11] Whether or not this is accurate, certainly all clinicians will concur that "skills training" remains an important part of what clinical education is all about. That is, clinicians seek to improve the quality of their students' lawyering, whoever the clients might be. It is appropriate, therefore, for this essay to analyze how effectively clinical courses satisfy this general goal.[12]

III. "CASE-CENTERED" CLINICAL COURSES

The case-centered approach to clinical legal education produces courses or programs that have four primary characteristics:

> 1. Clinicians organize courses around particular legal problems of poor and socially marginalized client populations. For example, a clinic might address problems involving "welfare rights;" "immigration" or "asylum" rights; or "children's rights."
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> 2. Students engage in a wide variety of lawyering tasks in the course of representing clients. For example, they typically interview and counsel clients, engage in discovery, negotiate with adversaries, and

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[9] William Pincus, *Educational Values in Clinical Experience for Law Students*, CLEPR NEWSLETTER, Vol. II, No. 1, Sept. 1969, *reprinted in* CLINICAL EDUCATION FOR LAW STUDENTS 78 (Council on Legal Educ. for Prof. Resp. ed., 1980).

[10] *Id.* at 83-84. For an explicit discussion of the meaning of "Teaching Social Justice in the Clinic" and what role clinicians might play in that process see Stephen Wizner, *Beyond Skills Training*, 7 CLIN. L. REV. 327 (2001).

[11] Michael Meltsner, *Celebrating The Lawyering Process* 10 CLIN. L. REV. 327, 342 (2003).

[12] For a more particularized description of the goals of In-House clinical programs, see *Report of the Committee on the Future of the In-House Clinic*, 42 J. LEGAL EDUC. 308, 511-17 (1992).

perhaps represent clients in court or administrative proceedings. However, the vagaries of individual cases mean that typically, not all students engage in each of these activities. For example, one student may appear in a contested hearing, while another student's cases settle or otherwise fall by the wayside before the hearing stage.

3. Case needs primarily dictate the lawyering tasks in which students engage. That is, most of the legal work that students do grows out of the effort to resolve clients' cases satisfactorily rather than out of an effort to provide training with respect to particular lawyering skills.

4. Students receive concurrent classroom instruction in an array of lawyering tasks. The subjects tend to mirror the tasks that students might potentially perform in the course of representing actual clients, such as interviewing and counseling.

While a summary of all law schools' clinical offerings is beyond the scope of this essay, most clinicians will undoubtedly recognize that most clinical courses continue to evince the four characteristics mentioned above. Thus, perhaps a few specific examples can suffice to illustrate the dominance of the case-centered approach. With respect to the first characteristic, consider these course titles of clinical courses that law schools currently offer or have very recently offered: Asylum and Immigration Clinic; Child Advocacy Clinic; Civil Rights Litigation (Mental Disability) Clinic; Health Insurance Counseling Project; Environmental Law Clinic. The courses reflect a case-centered approach in that the course titles describe the types of legal matters that students will work on while enrolled in the courses.

With respect to the second and third characteristics, consider the design of two of the country's outstanding clinical programs. Harvard Law School's Legal Services Center[13] houses six different programs, each devoted to a discrete type of legal problem that confronts low income clients.[14] A description of one of these programs, the Family and Children's Law Practice Clinic, demonstrates that students will engage in a wide array of lawyering tasks in the course of representing clients. According to the Program's description, students who enroll in this clinic "will interview and counsel clients, research factual and legal matters, develop case strategies, conduct written discovery and draft pleadings. Students often argue motions in Court, and appear at Probation Office negotiations, pretrial conferences, status conferences

[13] The full name of the center is the Hale and Dorr Legal Services Center, named after the large Boston law firm that provided much of its funding.

[14] Students' fieldwork is supervised by clinical instructors, who work in the Center full time.

and final hearings. In cases scheduled for full trial, students will have the opportunity to participate in depositions and conduct the direct and cross-examination of witnesses at trial. The unit also focuses on representing children in Special Education and Disciplinary matters involving administrative hearings."[15]

American University's Washington College of Law provides another example of the case-centered approach's second characteristic. The law college's description of its Domestic Violence Clinic indicates that students "conduct intake interviews. . . prepare and file court pleadings, conduct research and fact investigations, and handle settlement negotiations and all aspects of contested trials."[16]

Finally, in the case-centered approach the multi-task approach to skills training carries over to classroom instruction. For example, American University's Washington College of Law indicates that each of its eight live client clinics "offers student attorneys instruction in most of the following areas: Case Preparation, Interviewing, Case Theory, Legal Writing, Client Counseling, Negotiation, Decision Making, Oral Argument, Discovery Practice, Proof of Facts, Drafting Strategic Planning, Fact Investigation, Trial Advocacy, Informal Advocacy, Witness Preparation. . .."[17]

Professor Paulette Williams' account of the Divorce Clinic that was part of Cornell Law School's Legal Aid Clinic furnishes a second example of a case-centered clinical course that offers classroom instruction in a variety of lawyering skills. According to Professor Williams, her course provided students with classroom instruction in "client interviewing, fact gathering and investigation, legal research and problem analysis, client counseling, negotiation, oral advocacy, and written advocacy."[18]

Indeed, Professor Williams suggests that clinicians who teach clinical courses often devote classroom time to more than traditional lawyering skills such as interviewing and counseling. As she explains, "clinical educators often include principles and methods from feminist legal theory, critical legal theory, critical race theory, narrative, professional coaching, problem solving, and other innovative teaching models and methodologies in their teaching."[19] Support for Prof. Williams' assertion exists in messages that clinicians share on the "Clinical Listserve." For example, one clinician's recent message indi-

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[15] http://www.law.harvard.edu/Academic_Affairs/Clinical_Program/lsc/#top (last visited June 12, 2003).

[16] http://www.wcl.american.edu/clinical/domestic.cfm (last visited May 14, 2003).

[17] *Id.*

[18] Paulette J. Williams, *The Divorce Case: Supervisory Teaching and Learning in Clinical Legal Education*, 21 ST. LOUIS U. PUB. L. REV. 331, 337 (2002).

[19] *Id.* at 342-43.

cated that in an effort to increase the social justice emphasis of his "'regular' clinic," he asks students to read Marc Galanter's "How the Haves Come Out Ahead;" Donald Black's "The Behavior of Law and Sociological Justice;" Stephen Wexler's "Practicing Law for Poor People;" and the chapter on "Tactics" from Saul Alinsky's *Rules for Radicals*.[20] Of course, instructors who devote classroom time to topics such as these must of necessity devote that much less time to the variety of lawyering skills that their courses cover.[21]

Finally, the continuing popularity of the case-centered approach is also reflected in Teachers Manuals prepared by the authors of currently available textbooks on lawyering skills written for use in clinical courses. For example, the Teacher's Manual for *Essential Lawyering Skills*[22] suggests that the seminar component of clinical programs might meet two hours per week and cover the following skills: developing a legal theory of the case, client and witness interviewing, fact investigation (including depositions), counseling and negotiation.[23] Similarly, the Teacher's Manual for *Clinical Legal Education*[24] suggests that clinical programs' seminars should explore at least the skills of developing a theory of the client, interviewing, counseling, fact investigation and negotiating."[25]

IV. "TRANSFER" OF LEARNING FROM CLINICAL EXPERIENCES TO THE PRACTICE OF LAW

"Transfer" refers to a student's ability to employ skills in one context that have been learned in a different context.[26] Learning theo-

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[20] Message of Prof. Peter Davis posted to "Lawclinic" on June 5, 2003. For a perspective that clinical law teachers should train students according to the ethics and values of social workers, *see* Jane Aiken and Stephen Wizner, *Law As Social Work*, 11 J. OF L. & SOC. POL. 63 (2000).

[21] Incorporating perspectives on social justice into case-centered courses is consistent with one of the traditional purposes of clinical education, trying to imbue in law students an ethic of serving poor and socially marginalized client populations. All we mean to point out is that devoting classroom time to such perspectives may increase the tension between serving low income populations and engaging in effective skills training.

[22] STEFAN H. KRIEGER & RICHARD K. NEUMANN JR., TEACHERS' MANUAL, ESSENTIAL LAWYERING SKILLS: INTERVIEWING, COUNSELING, NEGOTIATION AND PERSUASIVE FACT ANALYSIS (2d ed. 2003).

[23] *Id.*

[24] DAVID F. CHAVKIN, CLINICAL LEGAL EDUCATION: A TEXTBOOK FOR LAW SCHOOL CLINICAL PROGRAMS (2002)

[25] *Id.*

[26] *See* National Research Council, HOW PEOPLE LEARN 51 (John D. Bransford, Ann L. Brown & Rodney R. Cocking eds., expanded ed. 2000); Anthony Marini & Randy Genereux, *The Challenge of Teaching for Transfer*, *in* TEACHING FOR TRANSFER 2 (Anne McKeough, Judy Lupart and Anthony Marini eds., 1995); Dee H. Andrews & Herbert H. Bell, *Simulation-Based Training*, *in* TRAINING AND RETRAINING 374 (Sigmund Tobias and J. D. Fletcher eds., 2000).

rists distinguish between "near" and "far" transfer. Near transfer occurs when students are able to apply skills that they have been taught to tasks that are relatively routine and repetitive in nature. In legal contexts, near transfer tasks would include preparing and serving subpoenas and drafting and serving standard pleadings. With near transfer tasks, surface features tend to remain consistent from one situation to another, and successful task performance does not require significant problem-solving.[27]

Far transfer, by contrast, involves situational adaptations and problem solving. Far transfer situations require the ability to adapt general principles to the unique needs of specific problems. That is, with "far transfer tasks, the performer must translate basic principles into tailored procedures to fit the unique needs of the situation."[28] In a legal context, far transfer tasks would include applying general principles of lawyering skills such as interviewing, counseling and negotiation to concrete inter-personal interactions.

As these brief descriptions of far and near transfer suggest, clinicians primarily should seek to promote far transfer. While some of the lawyering tasks that students will perform after graduation are routine in nature, practicing law typically requires situational adaptation and creative problem-solving. Thus, clinical courses effectively provide skills training to the extent that they enable students to transfer the concepts, strategies and techniques they begin to use while in clinical courses to the many and varied practice settings they are almost certain to encounter after graduation.

Undoubtedly, clinicians (like almost all educators) have at one time or another had thoughts such as, "I hope that my students can apply all that I've taught them to the problems they confront after graduation." For the most part, educators have no way of knowing the extent to which their efforts have promoted transfer. However, recent research by cognitive psychologists[29] and curricular changes made by medical school educators[30] suggest that educators can design training so as to enhance the likelihood that they will come closer to achieving far transfer. This essay suggests that clinical legal educators rethink their approach to skills training in light of what we now know about far transfer.

An established principle is that transfer is likely to occur only

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[27] For further discussion of near transfer, see Ruth Clark & Merlin C. Wittrock, *Psychological Principles of Training*, *in* TRAINING AND RETRAINING at 77 (Sigmund Tobias & J. D. Fletcher eds., 2000).

[28] *Id.* at 78.

[29] *See infra* this section.

[30] *See infra* Section VII.

when the training that students receive while in school develops concepts that become encoded in their long term memories.[31] Storing educational training in their long term memories enables students to retrieve and apply what they've learned to new situations that arise after graduation. The issue thus becomes how to design clinical courses in a way that promotes students' ability to conceptualize what they learn so that they encode those concepts in their long term memories. The subsections below suggest the types of factors that tend to promote far transfer.

A. Conceptual Understanding

Conceptual understanding occurs when students are aware of general principles underlying different skills or practices. Research into learning suggests that for transfer to occur, "knowledge of a large set of disconnected facts is not sufficient."[32] Rather, "organizing information into a conceptual framework allows for greater 'transfer;' that is, it allows the students to apply what was learned in new situations."[33] For example, students' understanding of the inferential process underlying circumstantial evidence can help them understand how to formulate discovery plans and what evidence to seek during discovery and trial. Conceptual frameworks tend to produce "metacognition," meaning that students become aware of their learning strategies and thus can continue to learn from their professional experiences.[34]

B. Content

Content is perhaps the most self-evident factor that affects transferability of training.[35] Students can transfer lawyering skills training to new situations only to the extent that they have received instruction in comparable situations while in school. Complex subjects such as interviewing, counseling and negotiation involve far more content than a collection of pat behaviors and verbal formulas that students

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[31] Encoding is "the process of relating incoming information to concepts and ideas already in memory in such a way that the new material is more memorable." MARCY DRISCOLL, PSYCHOLOGY OF LEARNING FOR INSTRUCTION 84 (1994). *See also* Gary L. Blasi, *What Lawyers Know: Lawyering Expertise, Cognitive Science and the Functions of Theory*, 45 J. LEGAL. EDUC. 313, 335-36 (1995).

[32] HOW PEOPLE LEARN, *supra* note 27, at 12, 67, 140, 257.

[33] *Id.* at 55-56. For a rich analysis of the role that theory plays in promoting learning, see Blasi, *supra* note 31, at 361-80.

[34] *See* Marini & Genereux, *supra* note 26 at 7, 16. *See also* HOW PEOPLE LEARN, *supra* note 26, at 67.

[35] *See, e.g.*, Driscoll, *supra* note 31; Daniel J. Givelber, Brook K. Baker, John McDevitt, & Robyn Miliano, *Learning Through Work: An Empirical Study of Legal Internship*, 45 J. LEGAL EDUC. 1, 17 (1995).

can memorize and apply verbatim to new situations. To encode training into clinical students' long-term memories in such a way that they can apply the training to new situations they confront as lawyers, instructors concerned about content might cover such matters as:

* Common problems of the type that students will encounter as lawyers. For example, assume that a clinical instructor believes that a common problem that arises during counseling involves clients' mistaken predictions about the likely consequences of their decisions. The content of the clinician's course should then include clients who make mistaken predictions.

* Effective strategies for responding to problems that practicing lawyers commonly face. In the example above, training should include strategies for responding to clients who make mistaken predictions.

* Factors that students should consider when exercising judgment about which of the potentially available strategies to employ when problems arise. For example, two strategies that a student might employ in response to a client whose predictions are likely to be mistaken are to ignore the client's seeming mistake and effectuate the client's decision, or to call the mistake to the client's attention. Clinical training should include factors that students should consider when exercising judgment about whether to follow one or the other of these strategies.[36]

* Ethical issues that often arise in connection with the exercise of lawyering skills. For example, training about counseling ought to include how lawyers might respond when clients want to make decisions that lawyers consider immoral or not in the clients' best interests. Similarly, training about trial representation skills ought to include analysis of how lawyers might respond when clients or witnesses seem prepared to testify falsely.

* Training in techniques for effectuating judgment. This aspect of content is inherent in clinical methodology, which relies on students performance in role, both real and simulated.[37]

C. Process and Structure

Process and Structure concern *how* instructors carry out training as opposed to the *content* of that training. For example, clinical instructors can promote the likelihood of transfer by incorporating the features set forth below into their courses.

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[36] Blasi, *supra* note 31, at 318 "[T]he core activity of lawyers entails problem solving and making decisions."

[37] Research findings support the importance of "active learning" methods such as simulations. *See* How People Learn, *supra* note 26, at 66.

* Students have several opportunities to practice using the skills that they will hopefully transfer into practice.[38] For example, if an instructor wants to develop students' competency in determining what evidence to look for during discovery, students should have a number of opportunities to try their hand at this task. Without repeated opportunities, concepts are unlikely to become encoded in students' long term memories.[39]

* Students encounter the same type of problem in different contexts. Research demonstrates that students accumulate knowledge through "many opportunities for observing similarities and differences across diverse events."[40] For example, you can enhance the likelihood that students will transfer their understanding of how to carry out time line questioning effectively by giving them opportunities to seek time lines from different clients in differing factual contexts. In the admittedly verbose but nevertheless insightful jargon of cognitive psychologists, "the use of varied context examples can build a robust schema, which will in turn support far transfer. In summary, a powerful instructional strategy to avoid inert knowledge to yield far-transfer performance is to provide varied context examples . . ., which will allow students to focus on building flexible schema based on the deep structure and show that it may be reactivated by a variety of surface features."[41]

* Students' practice experiences are spread out over time. Research by psychologists suggests that "the same amount of overall practice is much more effective for long term retention when the practice is distributed over time. . . . For example, four twenty minute segments distributed over two days is more effective than the same four twenty minute practice sessions over one day."[42]

* Students encounter simple tasks before more complex ones.[43] For instance, rather than students' first interviewing exercise consisting of an entire interview, clinicians would ask students to practice conducting individual parts of an interview such as preliminary problem identification, timeline questioning or T-funnel questioning.

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[38] Brenda Sugrue and Ruth Clark, *Media Selection For Training*, *in* TRAINING AND RETRAINING 220-21. (Sigmund Tobias and J.D. Fletcher eds., 2000); Clark & Wittrock, *supra* note 27, at 60. *See also* Dee H. Andrews and Herbert Bell, *Simulation-Based Training*, *in* TRAINING AND RETRAINING at 363. Of course practice alone will not necessarily promote transfer. Practice most effectively promotes transfer when it is accompanied by meaningful feedback. *See also* HOW PEOPLE LEARN, *supra* note 26, at 174-76. *See also* Blasi, *supra* note 31, at 377-78.

[39] *Id.* *See also* Givelber et al., *supra* note 35, at 16-17.

[40] *See* HOW PEOPLE LEARN, *supra* note 26, at 62-65, 78.

[41] Clark & Wittrock, *supra* note 27, at 78. For further discussion of the importance of varying contexts, *See also* HOW PEOPLE LEARN, *supra* note 26 at 62; *See also* Blasi, *supra* note 31.

[42] *See* Clark & Wittrock *supra* note 27, at 60.

[43] One term for this approach is "scaffolding." *Id.* at 66.

* Students regularly receive meaningful feedback on their performances.[44] "Time in time" feedback (that is, feedback that provides students with the opportunity to revise their thinking as they work on tasks) is likely to be particularly effective.[45]

* Students learn how to evaluate, and regularly practice, evaluating their own performances.[46]

* Students are given adequate time to learn.[47]

D. Use of Simulations

Use of simulations is a vital factor for effecting transfer. Research suggests that the "main instructional method [to accomplish transfer] is high fidelity simulation practice; that is, having maximum similarity between the learning environment and the context in which the acquired skills have to be applied."[48] Simulations are the ideal vehicle for providing the repeated opportunities for practice and feedback in a variety of factual settings that promotes conceptual understanding and thus transfer.

V. The Case-Centered Approach and Transfer

The transfer-enhancing factors described above suggest that despite its longevity, the case-centered approach to skills training that the Introduction to *The Lawyering Process* outlines is ill-suited to the successful transfer of lawyering skills. This may not be the message that many clinicians want to hear. However, as Gary Bellow once said, "As clinicians. . . we need to look harder at ourselves; we need to be less afraid of criticizing ourselves. . ..we also need to argue with each other in an atmosphere in which what is at stake goes beyond today's debate, yet does not constantly question the value of the en-

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[44] Feedback is meaningful when it "enhance(s) [students] abilities to recognize [significant] patterns of information" by focusing their attention "around core concepts or 'big ideas' that guide their thinking about their domains." How People Learn, *supra* note 26, at 36.

[45] *See* How People Learn, *supra* note 26, at 141; Andrews & Bell, *supra* note 38, at 382.

[46] How People Learn, *supra* note 26, at 12, 67, 140, 257.

[47] "It is important to be realistic about the amount of time it takes to learn complex subject matter. . . . In all domains of learning, the development of expertise occurs only with major investments of time . . . ." Id. at 56-58. Within the context of a single semester it seems unlikely that law students can become expert in any complex lawyering task. Furthermore, for any complex skill it seems highly unlikely that once or twice over lightly will establish an adequate basis for transfer, especially given the importance of practice in differing contexts and the significance of receiving frequent feedback and opportunities for self assessment. *Id.* at 77-78.

[48] Clark & Wittrock, *supra* note 27, at 78.

tire enterprise in which we are engaged."[49] Thus, we suggest that clinicians who employ it frankly assess the potential deficiencies of the case-centered approach by measuring its features against the factors promoting transfer described above.

The primary reason that the case-centered approach is likely to frustrate transfer of lawyering skills is simply that programs devote too little time to too many lawyering tasks. As examination of *The Lawyering Process* or any of the more recent books by clinicians devoted to lawyering skills quickly reveals, lawyering tasks such as interviewing, counseling, fact investigation, negotiation and trial advocacy are each extremely complex. For example, assume that a clinician decides to teach students about depositions strategies and techniques. Common problems that students will confront when they depose adverse witnesses include obtaining time lines, probing stories thoroughly through T-funnel questioning, uncovering and cementing helpful answers, undermining harmful answers, responding to evasive witnesses, and using documents effectively.[50] Devoting a class or two to deposition strategies and techniques and even having each student conduct one simulated deposition is simply inadequate for students to be able to transfer what they learn about these and other common deposition issues.

Nor is live client work likely to remedy this inadequacy. Relying on live client work for transfer tends to result in a number of deficiencies:

* Not all students in the same course engage in the same tasks. For example, some students may take a deposition or take a case to trial, others may not.

* Even students who engage in the same tasks are unlikely to confront an adequate range of representative common problems. For example, students' counseling experiences may or may not include the problems of clients who have difficulty deciding what to do and clients who make seemingly illogical or even immoral decisions.[51]

* Live client representation doesn't permit a "time in time" style of supervision. That is, clinicians cannot readily interrupt actual interviews or negotiations to offer immediate feedback on students' performances, and perhaps try to give students positive experiences by

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[49] Gary Bellow, *On Talking Tough to Each Other: Comments on Condlin,* 33 J. LEGAL EDUC. 619 (1983).

[50] *See* DAVID A. BINDER, ALBERT J. MOORE & PAUL BERGMAN, DEPOSITION QUESTIONING STRATEGIES AND TECHNIQUES (2001).

[51] Coverage of skills in courses with live client components tends to be more truncated than in simulated courses devoted to particular skills areas. *See* for example Kimberly E. O'Leary, *When Context Matters: How To Choose An Appropriate Counseling Model,* 4 T. M. COOLEY J. PRAC. & CLINICAL L. 104, 137 (2001).

asking them to "try this part again."

* Live client work often produces an "equal dignities" approach to skills training. That is, the need to provide quality representation typically requires clinicians to spend time on lawyering tasks that are straightforward or well taught in practice. As a result, clinicians often have to reduce the time they can give to more complex lawyering tasks that generally receive only scant attention in practice. For example, a clinician may have to devote substantial time to such "near transfer" matters as requirements for filing pleadings and arranging to receive copies of documents from adversaries, simply because cases require students to engage in those activities. By contrast, the dynamics of actual cases means that clinicians and students often have inadequate time to devote to important and complex concepts and skills relating to tasks that require "far transfer" and are likely to be not well taught in practice, such as taking depositions and conducting negotiations.

* For varying reasons including insuring high quality supervision, clinicians typically limit students' live client work to a very small number of cases.[52] As a consequence students have a limited number of opportunities to confront the varying contexts, important lawyering skills and ethical dilemmas they will face in practice.

* Clinicians often do not supervise all of the lawyer-client interactions that occur when students are in contact with clients. For example, clinical supervisors may observe and participate in students' initial meetings with clients, but often are not present when all follow-up meetings and phone contacts take place.[53]

Measuring the case-centered approach against other factors tending to promote transfer reveals further deficiencies. For example, the case-centered approach generally affords clinicians only enough time to provide each student with a single simulated counseling exercise. That single exercise does not allow for the "building block" methodol-

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[52] For a discussion of case supervision ratios and student case loads, *see* Robert Dinerstein *Report of the Committee on the Future of the In-House Clinic*, 42 J. LEGAL EDUC. 308, 538-40 (1992) and discussion on the "Clinical Listserve" during the period April 11, 2002 and April 13 2002. This discussion was initiated by Professor Judith L. Fox (Notre Dame) and responded to by Professors Randy Hertz (NYU), David Chavkin, (American) Kimberly O'Leary (Cooley), John J. Pottenger Jr. (Yale), Alan M. Lerner (Pennsylvania), Michael W. Mullane (Arkansas) , James Cohen (Fordham), Gary Palm (Formerly at Chicago) and Peter Joy (Washington U. St. Louis) Copies of their respective e-mails are on file with the authors. *See also* Philip G. Schrag, *Constructing a Clinic*, 3 CLIN. L. REV. 175 (1996) (describing the benefits both faculty and students receive by maintaining a small case load).

[53] *See, e.g.*, Robert Dinerstein, Stephen Ellmann, Isabelle Gunning & Ann Shalleck, *Legal Interviewing and Counseling: An Introduction*, 10 CLIN. L. REV. 281, 286 (2003). Quoting the authors' introduction to their forthcoming book, the essay provides a sample dialogue between two clinical law students and a client's sister that takes place at the sister's house apparently without supervision by their instructor.

ogy that promotes far transfer. Moreover, a single simulated exercise does not allow students to encounter similar problems in different contexts over a course of time, also undermining the likelihood of transfer.

VI. What Skills and Knowledge Might Clinical Law Teachers Seek To Transfer?

Assuming that some educational strategies are better than others for promoting transfer, one issue for law school clinicians concerns the skills and knowledge that they want law students to transfer from their clinical experiences to the practice of law. While you might respond by saying "I want them to transfer everything," the complexity of lawyering tasks and the intensity of the effort necessary for transfer to take place pretty much rule that answer out. For example, the repeated opportunities for practice in varied contexts that transfer seems to require and the complexity of such lawyering tasks as counseling, negotiation, mediation, and advocacy mean that clinicians are unlikely to have nearly enough teaching time to promote the transfer of all the strategies and skills related to such tasks. Thus, as in so many other aspects of life, clinicians need to prioritize among possible learning goals.

If you are a clinical law teacher, the skills and knowledge you emphasize in your courses will probably depend at least in part on factors such as your professional experiences and what you think that students can readily learn on their own from reading practice guides or consulting colleagues in practice once they graduate and begin to practice law. The following considerations may further your thinking about priorities:

* Ask yourself a question such as, "What are the important and complex problems that commonly confront lawyers as to which my students are unlikely to receive adequate training once they enter law practice?" Answers you arrive at constitute skills that you may want to prioritize. Such factors as your school's geographic location and the types of practices that students who graduate from your law school typically embark on may lead you to give priority to skills that another clinician would not choose to emphasize. However, that is a benefit and not a detriment of this method of thinking about priorities. In any event, thinking about priorities in this way probably means that "near transfer" tasks such as "serving subpoenas," "complying with technical aspects of summary judgment motions," and "discussing attorneys' fees" are unlikely to be effective priorities. When and if they embark on law practices, students will almost certainly learn those skills either on their own or under

supervision.[54]

* Consider the content of clinical teaching texts when deciding what skills and knowledge you seek to prioritize. *The Lawyering Process* has been joined by a rich array of books on the diverse topics that fall within the general domain of clinical legal education. Understanding what other clinicians consider to be the most important issues concerning such lawyering tasks as Interviewing, Counseling, Negotiation and Advocacy can help you think about the topics, skills and knowledge that you want to emphasize.

Whatever your priorities, seek to imbed them in all aspects of a course, including readings, classroom discussions, simulated exercises, and representation of actual clients. For example, if you want to help students develop conceptual understanding of skills related to interviewing, you might select relevant concepts such as time line questioning, active listening and probing conclusions. You may then ask students to read about these concepts, discuss them in class, create simulations that present students with opportunities to work with these concepts in different contexts,[55] and choose live client experiences that are likely to provide students with multiple opportunities to work with these concepts.

Empirical research into lawyers' mentoring activities and post-graduate development of students' lawyering skills would help clinicians make more educated judgments about what to prioritize in clinical programs. At present, such research is virtually non-existent. However, one small research project suggests that practicing lawyers receive little skills training. This project consisted of a survey of 407 lawyers. 60% of these lawyers reported that they received no practice or rehearsal training before taking their first deposition.[56] Moreover,

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[54] The fact that some clinical students may become sole practitioners or begin practice with a small firm does not in our opinion justify devoting substantial teaching time to "near transfer" tasks. One reason is that even sole practitioners have access to ample resources for learning about how to carry out routine and repetitive lawyering tasks. These resources include practice guides and more experienced lawyers, who are often more than willing to provide help to neophytes. A second reason is that time devoted to near transfer tasks may drown out the time available for complex lawyering tasks as to which neophytes are unlikely to receive any substantial training once they embark on legal practices. For example, "continuing education" courses for lawyers typically focus on substantive issues in discrete fields such as real estate, tax or family law, and are not structured so as to provide lawyers with substantial practice and feedback in complex tasks such as counseling and negotiation. Moreover, such skills training as is available to practitioners tends to be costly and limited to one or two days.

[55] For example, you might adopt a "scaffolding" approach by creating simulated exercises that ask students only to develop timelines; they need not conduct the earlier or later phases of interviews until after they have sufficiently practiced how to conduct timeline questioning.

[56] This research was conducted by David A. Binder during 2000-2001. Copies of the survey results are on file with the authors.

half reported never having reviewed with a more senior litigator a transcript of a deposition that they had taken. If additional research confirms that only such meager training opportunities are available once law students enter the profession, clinicians need to pay particular attention to problems of transfer.[57]

VII. Enhancing Transfer Through "Skill-Centered" Clinical Courses

The transfer factors described above suggest that "skill-centered" clinical courses may better promote transfer of lawyering skills as compared to the "case-centered" approach. In a "skill-centered" approach, clinicians organize classroom and live client work primarily around the skills they seek to have students transfer rather than around specific types of legal cases. The skills-centered approach to course design in no way denigrates the importance of the substantive rules that are relevant to clients' problems, because skills training is meaningless in the absence of legal rules. Nor is it necessarily inconsistent with the "social justice" emphasis that has been an aspect of clinical education since its inception, because students' live client work and training in simulated contexts can continue to focus on problems affecting poor and socially disadvantaged clients. Thus, the skill-centered approach endeavors to ensure that clinical education produces lawyers who are both "highly moral and instrumentally competent."[58]

Sub-section B below describes alternative skill-centered course approaches. First, however, consider recent developments in medical school skills training pedagogy. These developments are of particular relevance to law school clinicians because the traditional medical school approach of providing practical training principally by rotating students through various medical specialties and examining patients under their supervisors' trained eyes was the model for clinical legal education.[59] Medical schools evaluated this traditional approach in the light of transfer factors and have found many of the same deficiencies that exist with the case-centered approach to clinical legal education. The observations and changes in medical schools' professional skills training programs are thus instructive for legal clinicians.

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[57] For further discussion of future research directions, see *infra* Section VIII.

[58] *See* Blasi, *supra* note 31 at 313, 396 ("Lawyering of course entails 'moral reason and ethical sense' as well as proficiency in instrumental problem solving. But recognizing the [former] is no excuse for giving short shrift to the [latter]. The world is full of highly moral but instrumentally incompetent lawyers. Whether they do more harm than less moral but more able lawyers is an empirical question. In any event, one need not insist on the primacy of any single dimension of lawyering practice.").

[59] *See* Pincus, *infra* note 60.

A. *Lessons From Medical School*

Medical schools' traditional methodology of providing practical training almost exclusively through "case rounds" formed the template for clinical legal education.[60] Thus, it should be of particular interest to clinical legal educators that medical school educators have in recent years altered their "case-centered" approach in favor of "skills-centered" training along the lines that this essay suggests. Significantly, medical schools have substantially increased the amount of training time they devote to clinical skills, typically embedding clinical skills training in the entire medical school curriculum.[61] Moreover, medical schools have substantially increased their reliance on simulations for providing skills training.

Interestingly, the deficiencies that led medical school educators to take skills training more seriously echo those that exist with the case-centered approach to clinical legal education. For example, medical schools realized that their heavy reliance on the case rounds approach often:

* Failed to expose medical students to common but important medical problems.[62] That is, as with clients in clinical legal settings,

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[60] *See, e.g.*, WILLIAM PINCUS, CLINICAL EDUCATION FOR LAW STUDENTS 120-121, (CLEPR 1980). "Clinical education moves law schools closer to the professional schools like medicine and social work, where the avowed purpose is to produce practitioners," *Id.* at 120-121, 149; "The law schools will probably become more like medical schools, with a substantial part of the curriculum being devoted to clinical work." *Id.* at 136; "Clinical education in the law school will exert a profound influence on legal education, probably by moving legal education closer to the professional schools like medicine and social work." *Id. at* 152; "It is taken for granted that medical students have to spend nights, weekends, even summers learning the dirty work on emergency calls, in wards, etc. Why not law students to advise those who are arrested in the middle of the night?" *Id.* at 159; "By using certain practitioners as clinical law teachers (as in medical school), the law school will see itself as much a part of the profession as a part of the university." *Id.* at 189; "Clinical work demands law school control of the clinical setting—as the medical school controls its teaching hospital." *Id. at* 198; "The CLEPR programme clearly defined its focus as being that of clinical education, involving lawyer-client experience under law school supervision for credit, akin to the clinical teaching method in medical school." *Id.* at 348.

[61] Conversations with LuAnn Wilkerson, Sr. Associate Dean for Medical Education UCLA School of Medicine on April 15, 2001, June 17 and June 18, 2003.

[62] *See Proceedings of the AAMC's Consensus Conference on the Use of Standardized Patients in the teaching and Evaluation of Clinical Skills (Session One)*, 68 ACADEMIC MEDICINE (1993) [hereinafter "Proceedings"] (Speaker Howard S. Barrows: "I used the standardized patient during the clinical clerkship to provide the students with neurological problems that were important from them to encounter, yet might not occur spontaneously on the clinical service. The standardized patient could compensate for one of the major problems of clerkship training: the faculty has no control over the patient experiences that students have. By using standardized patients, some of the common and important problems in neurology would always be experienced by the students during their clerkships."). *See also* J.M Van Rossum, *The Leiden Alco: An Example of Systematic Present-Day Clinical Teaching in the Netherlands*, *in* CLINICAL TEACHING, PAST AND PRESENT 175 (H. Beukers & J. Moll eds., 1989) ("A major problem in medical education is the use of

working with actual patients was often a hit-or-miss method of exposing medical students to a range of common problems.[63] For a specific illustration, consider this comment made by a Senior Associate Dean at the UCLA Medical School:[64]

> An ability to diagnose coughs properly is important for the proper medical treatment of children. However, medical students whose pediatric rotations occurred during summer months typically did not have an opportunity to diagnose children's coughs because children's coughs do not usually develop during the summer.

* Did not permit medical students to move from simple to complex problems.[65]

* Did not allow medical students to get repeated exposure to the same problems in different contexts.[66]

* Frustrated both supervisors' ability to give meaningful feedback and students' opportunities for self-assessment.[67]

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patients for the initial training of basic skills."). *See also* Greg Meyer, David I. Lewin, John Eisenberg, *To Err is Preventable: Medical Errors and Academic Medicine*, 110 AM. J. MED. 597 (2001) (describing the prevalence of medical errors which have been recently spotlighted by the media and examines how they can be prevented by focusing on them in medical school curricula and making discussion of patient safety issues an important part of residency training).

63 See Meyer et. al., *supra* note 62; *see also* JANE WESTBERG & HILLIARD JASON, COLLABORATIVE CLINICAL EDUCATION: THE FOUNDATION OF EFFECTIVE HEALTH CARE 192 (1993) ("The numbers of patients, the range of clinical conditions, and the complexity of the tasks for which the learners have responsibility tend to be controlled mainly by the vicissitudes of the clinical service to which they are assigned.").

64 Conversation with LuAnn Wilkerson, Sr. Associate Dean for Medical Education, UCLA School of Medicine (April 15, 2002).

65 *See* NANCY T. WATTS, HANDBOOK OF CLINICAL TEACHING: EXERCISES AND GUIDELINES FOR HEALTH PROFESSIONALS WHO TEACH PATIENTS, TRAIN STAFF OR SUPERVISE STUDENTS (Churchill Livingstone 1990).

66 See *Proceedings, supra* note 62 (describing the advantage of using a standardized patient to present the same problem for all students in different contexts rather than relying on unpredictable real patients to provide meaningful exposure to a particular problem). *See* Watts *supra* note 65, at 127-28.

67 *See* KAAREN C. DOUGLAS, MICHAEL C. HOSOKAWA & FRANK H. LAWLER., A PRACTICAL GUIDE TO CLINICAL TEACHING IN MEDICINE 11-13 (1988). *See* Watts, *supra* note 65, at 128 ("Even when the clinical teacher is highly selective, many excellent opportunities for learning are difficult to use efficiently. Some important events occur unexpectedly and are ignored or used poorly because the instructor had not planned for them. . .[Students] may fail to notice important events, and make errors or achieve wonders without this being reinforced by the instructor."). *See also* FRANK T. STRITTER & MERREL D. FLAIR, EFFECTIVE CLINICAL TEACHING 42-43 (1980). "In a study of students' and faculty members' perceptions of feedback on a clinical clerkship, Gil and colleagues (1984) found that students value feedback but reported that specific points concerning needed improvement were not emphasized enough and were not made early enough during the clerkship to enable them to make improvements. In addition, they perceived feedback from their teachers to be generally inadequate, vague, and nonspecific. Irby (1986) reported that students at the University of Washington School of Medicine who rated the clinical teachings at their insti-

Finally, even though the practice of medicine is very different from the practice of law, the tasks that medical schools focused on when concluding that simulations are a necessary accompaniment to case rounds strongly resemble lawyering tasks that typically are the focus of clinical legal education. Medical schools concluded that case rounds alone typically failed to promote students' abilities to:

* Take medical histories;[68]

* Diagnose medical problems;[69]

* Develop technical competency for properly performing routine medical procedures;[70] and

* Develop inter-personal skills for communicating effectively with patients.[71]

Thus, medical schools' diagnosis that "case rounds often fail to promote transfer" should be of great interest to legal clinicians. Of equal import, however, should be medical schools' primary educational remedy: substantially increased reliance on simulations. For example, the "Standardized Patient" is one form of simulation widely used in medical schools. Standardized Patients are "actors" (typically community volunteers) who become "patients" with specifically defined backgrounds, physical symptoms and emotional and psychologi-

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tution, gave teachers the lowest score for 'provides direction and feedback.' Irby said this is not unique to his institution and that feedback from written evaluations of students' performances is as inadequate as oral feedback because of faculty members' lack of specificity in identifying students' strengths and weaknesses. . . . When faculty think they are providing feedback, their students and residents do not always agree. Collins and colleagues (1978) found that 79% of the physician faculty members they surveyed felt they were assessing their trainees' skills on rounds. Only 46% of the trainees perceived that such assessments were occurring. Similarly, Stritter and his colleagues (1975) found that groups of teachers consistently asserted they provided far more and better feedback than their students felt they received." WESTBERG & JASON, *supra* note 63, at 301.

[68] *See* WATTS, *supra* note 65, at 9-11.

[69] *See Proceedings*, *supra* note 62 (Speaker Howard S. Barrows, MD, relates his experience using standardized patients during the clinical clerkship at McMasters University to compensate for one of the major problems of clerkship training: the faculty had no control over the patient experiences that students have. By using standardized patients, each student would be responsible for learning and diagnosing some of the common and important problems in neurology that would otherwise have been missed when working with actual patients.)

[70] *See* Greg Meyer, David I. Lewin & John Eisenberg, *To Err is Preventable: Medical Errors and Academic Medicine*, 110 AM. J. MED. (2001). *See also* CLINICAL TEACHING, PAST AND PRESENT (H. Beukers & J. Moll eds., 1989) (describing the use of simulation techniques in an Amsterdam medical clinic as a staircase that gradually increases the students' competence to a level that is sufficient to work with actual patients).

[71] *See* DOUGLAS ET AL., *supra* note 67. *See also* David T. Stern, *Practicing What We Preach? An Analysis of the Curriculum of Values in Medical Education,* 104 AM. J. MED., Issue 6 (1998) (describing how the values of professional respect and the importance of service are not adequately addressed in resident rotation and in-patient internal medicine teams.)

cal traits.[72] Standardized Patients respond to the "content" aspect of transfer because they are trained to describe symptoms according to the design of each simulation. Also, Standardized Patients provide students with repeat experiences in different contexts.[73] For example, students take histories and diagnose and prescribe treatment for their "patients" in a variety of medical settings.[74] These patients differ not only in terms of their medical problems but also in terms of their personalities, mental acuity and cultural backgrounds.[75] Other patient simulations involve "live patients." Medical students take histories and conduct physical exams of people who volunteer to provide students with practice in various clinical skills.[76]

Other medical school simulations provide students with repeat experiences in different contexts through computer and videodisc programs, mannequins and models.[77] Two of the most highly-regarded computer-controlled patient simulators are "Stan" and "Harvey." "Stan's" programming can confront medical students with more than 75 patient profiles, including a truck driver with heart and lung disease and a victim of a gunshot wound. This sophisticated medical mannequin can also mimic rare complications like malignant hyperthermia, an adverse reaction to anesthesia that new physicians might not see in four years of residency training.[78] "Stan" allows medical students "to

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[72] For a thorough and excellent description of the "Standardized Patient" design and a discussion of how legal clinicians might adapt the design, *see* Lawrence M. Grosberg, *Medical Education Again Provides A Model for Law Schools: The Standardized Patient Becomes the Standardized Client*, 51 J. LEG. EDUC. 212 (2001).

[73] *See* WESTBERG & JASON, *supra* note 63, at 183. It has been estimated that on average each current graduate of UCLA Medical School will encounter 40 standardized patients during the student's four years in medical school. Conversation on June 18, 2003 with Elizabeth O'Gara, Director of the Standardized Patient Program at UCLA Medical School (June 18, 2003).

[74] For example taking histories and conducting physical examinations are now part and parcel of the educational path followed in most clinical rotations. *See* DOUGLAS ET AL., *supra* note 67, at 11.

[75] Conversation with Elizabeth O'Gara, Director of Standardized Patient Program, School of Medicine, UCLA, (June 18, 2003). *See* DOUGLAS ET AL., *supra* note 67, at 11; WATTS, *supra* note 65, at 11.

[76] For example, gynecological teaching associates (GTAs) are standardized patients who are trained to present gynecological and breast histories, teach pelvic and breast examinations as they are performing them and give feedback from the patient's point of view. See http://www.med.mun/ca/munmed/132/pages/gynecological.htm (last visited June 27, 2003). Men also serve as "live patients" for purposes of providing training in the examination of male genitalia. *Id.*; conversations with LuAnn Wilkerson, Sr. Associate Dean for Medical Education UCLA School of Medicine (June 17 and 18, 2003).

[77] *See* DOUGLAS ET AL., *supra* note 67, at 98. (describing a computer program that provided training concerning symptoms that produced the 10 most frequent diagnoses in family practice doctors). Paper-Based patient management problems are also seen as useful; *See* WESTBERG & JASON, *supra* note 63, at 194.

[78] http://hsc.usf.edu/PUBAFF/hot/stan.html (last visited May 2, 2001).

perform common medical procedures. But even more important, proponents say, is the way it puts learners in complex, realistic situations where judgment, communication, and teamwork are crucial."[79]

"Harvey" is a Cardiology Patient Simulator. "Harvey" is a life-sized mannequin that can confront students with 27 cardiovascular conditions (two normal conditions and 25 cardiovascular diseases). Harvey provides students not only with the opportunity to study various cardiac conditions but also allows them to "practice bedside examination techniques under realistic conditions without the difficulty of finding an appropriate group of available cardiology patients."[80]

Medical schools also promote transfer through sensitivity to the importance of sequential learning. For example, students practice on simple problems before complex ones, on simulated patients before actual ones, and in low stress environments before high stress environments.[81] Use of the "time in time" supervisory technique also allows observers to interrupt simulated sessions to provide immediate feedback to students.[82] And meta-cognition is typically an explicit goal of medical school practical training. That is, making students aware of the methods of critiquing their own performances enhances the likelihood that students will continue to learn from their professional experiences.[83]

So profound have been the changes in medical education that beginning in the year 2005, a portion of the National Licensing Examination that all of the approximately 17000 medical students applying annually to practice medicine will have to pass will include a "Clinical Skills Examination."[84] The examination will require each student to

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[79] http://focus.hms.harvard.edu/2001/May4_2001/medical_education.html http (last visited June 17, 2003). See also www.hmiworld.org/past_issues/May_June_2002/macy.html, (Last visited on June 17, 2003).

[80] http://library.nymc.edu/HARVEY/Harvey.htm (Last visited on June 13, 2003). For examples of additional computer based simulators used in medical education including those used to provide practice in endovascular procedures such as pacemaker leads placement, angiography and angioplasty and endoscopies, see http://www.immersion.com/ (Last visited on June 17, 2003). *See also Simulation Technology for Health Care Professional Skills Training and Assessment*, 282 JAMA 861-866 (1999).

[81] *See* WATTS *supra* note 65, at 9-11. *See also* J. M. Van Rossum, *The Leiden Alco: An Example of Systematic Present-Day Clinical Teaching in the Netherlands*, *in* CLINICAL TEACHING PAST AND PRESENT (H. Beukers & J. Moll eds., 1989).

[82] Remarks of Dr. Howard S. Barrows during Session One, *Proceedings, supra* note 62.

[83] WESTBERG & JASON, *supra* note 63, at 277-80. Of course, many clinical law teachers also seek to achieve meta-cognition. The suggestions for transfer that this essay discusses hopefully promote the likelihood that meta-cognition will in fact occur.

[84] http://www.usmle.org/news/cse/csefaqs2503.htm. (Last visited June 17, 2003). "Standardized Patients," are laypeople who have been trained to act like real patients. *See* Grosberg, *supra* note 72, at 212. Doctors from foreign countries who apply to practice in the United States will also have to take and pass this exam. Conversations with LuAnn Wilkerson, Sr. Associate Dean for Medical Education UCLA School of Medicine. (April

take a history and conduct a physical examination of ten "standardized patients" and after each examination "to record the pertinent history and physical findings, list diagnostic impressions and outline any plans for further evaluations."[85]

In sum, medical schools have significantly changed their practical training programs and examination processes so as to better promote transfer of skills and knowledge after students graduate. Perhaps it is time for legal clinicians to consider alterations of their own.

B. Approaches to "Skill-Centered" Clinical Courses

The subsections below briefly describe a variety of possible approaches for making clinical courses more skill-centered. As you read through these alternatives, remember that our purpose is to promote discussion, not to suggest that clinicians adopt any of these "as is." Clinical programs vary greatly from one school to another, and the mix of case-centered and skill-centered courses that may work well in one law school may not necessarily work for another. Nonetheless, what all the approaches suggested below have in common is that they tend to enhance conceptual understanding by providing students with repeat and varied experiences in specific skill areas.

1. The Borrowing Model

The "borrowing model" involves establishing informal "partnerships" between clinical programs and lawyers in public interest law firms, legal services offices or private law firms who have taken on social justice cases on a pro bono basis. Together, the partners select appropriate cases and decide on the work that clinical students will do on those cases. Clinicians can select portions of cases that provide students with repeated experiences with the same complex lawyering tasks over a course's entire duration. For example, a clinician who wants to promote transfer of skills relating to fact investigation and depositions can chose to have students work on important discovery tasks that generally are not well taught in practice, such as preparing deposition outlines and undermining unanticipated harmful evidence. A clinical instructor can thereby provide students with repeated experiences in the skills on which a course centers. That is, students repeatedly use those skills in their casework, and readings, classroom discussions and simulated exercises focus on these skills as well. At the same time, the lawyer "partner" can perform tasks that may be necessary to the overall case but that don't relate to the skills on

15, 2001, June 17 and June 18, 2003).

[85] http://www.usmle.org/news/cse/csefaqs2503.htm. (Last visited June 17, 2003).

which the clinician seeks to focus.[86] The repeated opportunities to engage in the same tasks in different contexts and in both simulated and actual settings combine to make this an effective approach for promoting transfer.[87]

2. *The "More About Less" Approach*

Without changing students' live client work, clinicians may better promote transfer by focusing readings, classroom discussions and simulations on one or two lawyering tasks. Of course, the tasks should be those that all or nearly all students will engage in when representing clients. For example, if students routinely interview and counsel clients, then a clinician may decide to base nearly all classroom discussions and simulations on those tasks. Using such an approach probably means that students will engage in tasks while representing clients that their clinical supervisors have not covered during classroom meetings and simulations. However, the same phenomenon occurs under the case-centered approach, if for no other reason than that students may have to engage in lawyering tasks before their clinical supervisors can cover them in class or during simulations. Under either approach, then, clinicians almost certainly teach some skills primarily in the context of supervising actual cases.

3. *"Choose Your Skills"*

A clinical program that adopts the "More About Less" approach described above may promote transfer by allocating different lawyering tasks to different clinical courses and allowing each student to enroll in the course that focuses on the tasks that student wants to pursue, regardless of who is supervising the student's live client work. For example, assume that a clinical program offers courses in "Children's Rights" and "Workers Rights." The classroom and simulated exercise aspects of the Children's Rights course might focus on courtroom advocacy skills, while the classroom and simulated exercise aspects of the Workers Rights course might focus on mediation and arbitration. In such a situation, it may be possible for students to do live client work in one course yet take the classroom portion of the

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[86] For example, the lawyer partner might appear in court in connection with discovery-related motions.

[87] A by-product of the borrowing model is that it may increase students' desire to perform public interest legal work. Whether the lawyer "partner" is a legal services attorney or is a private practitioner taking a case on a pro bono basis, students may realize how limited the resources are for providing legal services to poor or socially marginalized clients. This realization may in turn impel students at least to perform pro bono legal work, no matter what career path they choose.

other.[88]

4. Select Cases From A Skills Perspective

Another option for increasing the likelihood of transfer is to select cases that are most likely to provide students with live client experiences that involve the lawyering skills that a clinician seeks to emphasize. For example, an instructor who teaches a trial skills-centered course may select cases that are nearing trial (or hearing before an administrative law judge) and are unlikely to settle, such as asylum cases. Similarly, a clinician whose course focuses on interviewing and counseling skills may have students work with clients who seek advice. Clients whose matters extend much beyond advice-giving may be referred to other clinical programs in the school or to outside lawyers.[89]

5. Use More Simulations

Perhaps simulations will never capture students' passions to the same extent as live-client matters.[90] However, especially in conjunction with representation of actual clients, simulations often do generate considerable student motivation. Students' understanding that the skills they develop by engaging in simulations will transfer into their work on actual cases tends to spawn high levels of student interest and enthusiasm.[91] Interest and enthusiasm are especially likely when clinicians develop simulations that closely parallel actual cases that a clinical program or practicing lawyers have previously undertaken.[92] Moreover, as Bellow and Moulton recognized in the Introduction to *The Lawyering Process*[93] and as Mike Meltsner reminds us in *Celebrating The Lawyering Process*, simulation has to be an essential part

[88] Undoubtedly this approach would require clinicians to overcome a variety of administrative and professional responsibility hurdles. For example, if some classes and simulated exercises are devoted to the substantive knowledge that students need to represent clients competently, students would have to participate in those classes and exercises. Thus, we mention this alternative simply to promote thinking, not because we think it is a sure fire winner "as is."

[89] The UCLA School of Law has adopted this model for some of its clinical courses and currently offers skill-centered courses for both trial advocacy and interviewing and counseling.

[90] *See* Deborah Maranville, *Passion, Context and Lawyering Skills: Choosing Among Simulated and Real Clinical Experiences*, 7 CLIN. L. REV. 123 (2000).

[91] These effects are evidence not only in students' comments but also in the extensive written work they generate in preparing for and subsequently critiquing their own performances in simulated exercises.

[92] The students' interest emanates in part from comparing what happened during the simulated "re-enactments" to what happened in the actual cases. For example, students who in a mock deposition exercise try to develop a timeline of relevant events can compare and discuss the strategies and questions they used to the lines of inquiry used in the actual deposition.

[93] See B & M, *supra* note 1, at xxiv.

of lawyer training.[94] If anything, the changes in medical education summarized above serve only to underline the importance of simulation. In sum, an alternative for promoting transfer is to increase substantially the number of simulated exercises that students engage in during clinical courses.[95]

A variant of this approach for schools that offer a substantial number of clinical courses is to assign one or two clinicians per semester to supervise the simulated exercises for students enrolled in other clinical courses. Clinicians might rotate back and forth between working on actual cases and conducting simulations. Besides assisting transfer, occasionally freeing clinicians from working on actual cases is likely to result in increased opportunities for scholarship relating to lawyering skills. Of course, a potential downside is that unless clinicians and students devote even more time to clinical courses than they do now, increasing the amount of faculty resources devoted to simulations may undermine the amount of time that clinicians and students can devote to live client work.[96]

At the same time, simulations come in a variety of shapes and sizes, and a simulation can be effective for promoting transfer even though it is a pencil-and-paper exercise that an entire class experiences together. For example, a classroom simulation might engage

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[94] *See also* MICHAEL MELSTNER & PHILIP G. SCHRAG, TOWARD SIMULATION IN LEGAL EDUCATION (1975).

[95] Clinicians have almost always included simulations in their teaching packages. *See* for example Dinerstein, *supra* note 52. *See also* Elliot S. Milstein, *Clinical Education in the United States*, 51 J. LEGAL EDUC. 375, 377 (2001). At the same time, however, clinicians have often voiced some skepticism about simulations. For instance, arguments have been made that simulations fail to teach "responsibility for clients," and that only live client experiences can achieve this important goal. *See* Dinerstein *supra* note 52. *See also* Ann Jurgens, *Using the MacCrate Report to Strengthen Live-Client Clinics*, 1 CLIN. L. REV. 411, 418 (1994). This argument may have some merit, particularly for students who work from beginning to end on cases involving individual clients. However, clinicians often confess when talking to each other in person and over the "Clinical Listserve" that they are frequently disappointed in their students' commitment to their clients. Moreover, it may be that to some extent, students' perceived failings are due to their feelings that they have not had the time and experience to develop the skills necessary to address their clients' problems adequately. For additional discussions of the potential drawbacks of using simulations, *see* Stephen Wizner, *Beyond Skills Training*, 7 CLIN. L. REV. 327, 333 (2001); Philip M. Genty, *Clients Don't Take Sabbaticals: The Indispensable In-House Clinic and the Teaching of Empathy*, 7 CLIN. L. REV. 273, 282-83 (2000); Maranville, *supra* note 90, at 134-35; Linda F. Smith, *Designing an Extern Clinical Program: As You Sow, So Shall You Reap*, 5 CLIN. L. REV. 527, 532 (1999); Fran Quigley, *Seizing the Disorienting Moment: Adult Learning Theory and the Teaching of Social Justice in Law School Clinics*, 2 CLIN. L. REV. 37, 69-70 (1995); Nina W. Tarr, *Current Issues in Clinical Legal Education*, 37 HOW. L.J. 31, 36 (1993).

[96] Another downside of this alternative might be a lost opportunity for the clinicians who supervise students' work on actual cases to help students understand how their performances in simulated contexts have affected what happened during their work on actual cases.

students in a written analysis of a portion of a transcript of an interview, with students analyzing the problem confronting the lawyer, the effectiveness of the lawyer's response, and possible alternative responses.[97]

Perhaps like their medical school counterparts, clinicians can also develop computer-based simulations. For example, interactive computer-based simulations might involve client interviews, depositions or negotiations. For instance, as a deposition unfolds on a computer screen, students might respond to questions or choose from among options that pop up on the screen.[98] Simulations such as these may be a valuable precursor to more complex simulations that require students to actually engage in lawyering tasks.[99]

Finally, clinicians from various law schools might come together to create "Standardized Client" simulations that, like the Standardized Patient's inclusion in future Clinical Skills Examinations for prospective doctors, can ultimately become the basis for a bar examination unit testing prospective attorneys' lawyering skills.[100] Larry Grosberg recently envisioned using Standardized Clients in clinical legal education and even on bar examinations. The lessons

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[97] Bellow & Moulton suggest the use of this type of simulation. *See* B & M, *supra* note 1, at xxiv.

[98] For an informative and detailed discussion of creating and using interactive video programs to test students' lawyering skills, see Lawrence M. Grosberg, *Shouldn't We Test For Interpersonal Lawyering Skills*, 2 CLIN. L. REV. 349, 365-84 (1996). These simulations might "ask the user to make choices at various points during the viewing of a lawyering activity and then (via the computer) to direct the person on the videotape to execute choices. Such a program would require the test taker 'virtually' to perform, and would also press the examinee to address the impact of context as he or she coped with the results, at later stages of the video, of the choices made earlier." *Id.* at 382-83. Of course developing sophisticated simulations might require considerable time and financial resources. However, clinicians from different schools might work together to create these kinds of educational devices.

[99] In many clinical programs, law students play the roles of clients, witnesses, etc. in other students' simulations. Beyond the convenience, a value of this approach is that law students may increase their appreciation of how important common lawyering tasks such as interviewing and depositions feel to non-lawyers. Nevertheless, law schools can enrich the value of simulations by involving lay and professional community volunteers in addition to or instead of law students in simulated exercises. The change of context adds realism to simulations and thus tends to promote transfer. UCLA runs a "witness program" that utilizes the services of approximately 200 community volunteers from various walks of life. In the clinical component of his Sports Law course our colleague Steve Derian is aided by executives of the Los Angeles Dodgers and the Los Angeles Lakers who play themselves in exercises designed to give students experiences in drafting and negotiation.

[100] If the experiences of medical educators serve as a guide, getting to the point that clinical legal education can use "simulated clients" on a national basis will probably require that clinicians work together over a period of time to tackle a variety of issues. These are likely to include questions such as: What should be the content of the standardized cases? How should standardized clients be trained? What criteria should be used to evaluate student performances?

from medical school suggest that it is time to "take Larry seriously."

VIII. Beyond Transfer

A potential by-product of developing skill-centered courses is that they may spur clinicians to develop empirical research agendas. For example, the subjects on which a researcher might seek to gather data include existing levels of practitioners' skills and the extent and effectiveness of law firms' mentoring and training programs for neophyte lawyers. Research projects may focus on a range of types of practitioners, such as government lawyers and private practitioners; public interest lawyers and legal aid practitioners; solo/small firm lawyers and large firm lawyers; and plaintiffs' lawyers and defense lawyers. Likewise, the research might take account of different substantive law specialties as well as geographical diversity. The results of such research may help guide the future development of clinical programs, keeping them current with the needs of practicing lawyers.

Also, clinicians might conduct research into the ability of the case-centered and alternative approaches to clinical education to promote transfer of lawyering skills. The reality is that in whatever context transfer has been studied, "achieving significant transfer of learning has proven to be a difficult chore. . . the research literature is replete with reports of failure."[101] While we think that empirical research has the potential to improve clinical programs' quality and relevance, we do not promote particular research designs. The results of this varied research could assist clinicians in constructing exercises designed to promote transfer for their particular students. The results might also help clinicians decide matters such as on what common problems simulations should focus on and how to vary contexts to promote transfer.[102] For example, the research might help clinicians reach a consensus on what are the common problems that lawyers face during follow-up interviews and what variations in context could usefully built into simulations to maximize transfer.

Organizations such as the AALS Clinical Section and CLEA could perhaps help promote empirical research along the directions just noted by holding programs to educate clinicians about how to conduct such research. Ultimately, research (perhaps supported by

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101 *See* Marini & Genereux, *supra* note 26, at 1.

102 For an excellent discussion of the contextual variables one might consider using when helping law students learn to counsel clients, *see* O'Leary, *supra* note 51 at 113-37. For additional discussions of subjects on which clinicians might conduct empirical research, see *id.* at 139; Blasi *supra* note 31; Richard K. Neumann, Jr. & Stephan Krieger, *Empirical Inquiry Twenty Five Years After "The Lawyering Process,"* 10 Clin. L. Rev. 349 (2003).

lobbying efforts of these organizations) might establish that "legal process" subjects such as interviewing, counseling, negotiation, fact investigation and mediation deserve a place on bar examinations.[103]

IX. Conclusion

This essay has argued that the case-centered approach to clinical education probably does not adequately foster students' capacity to transfer into law practice the skills for carrying out such important lawyering tasks as interviewing, counseling, negotiating and advocacy. Additionally this article has suggested that post-graduation transfer of lawyering skills requires that students have more opportunities to practice those skills in a systematic way and in varying contexts, with frequent feedback and continual opportunities for self assessment.

Clinicians who support the values represented by the case-centered approach may worry that increased focus on transfer will take away from client service and from imbuing students with the need to continue to devote time to the legal needs of poor and underserved clients. We recognize that tensions between the two longstanding goals of "client service" and "lawyering skills" that William Pincus identified may exist, and that increased focus on one may detract from the other. At the same time, the alternatives to the case-centered approach to live client work described above suggest that the goals may be compatible. That is, these or similar alternatives may increase lawyer competence while at the same time promoting clinical education's social justice goals. Perhaps changing the emphasis of clinical courses in the ways this essay explores will be even more effective than the

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[103] For a further discussion of such possibilities *see* Grosberg, *supra* note 72. *See also* CLEA Newsletter, Vol. XI, No. 4, 3-7 (May 2003) in which CLEA sets forth its presentation to the Standards Review Committee of The Council of Legal Education regarding revisions to ABA Accreditation Standard 304. In 1980 the State Bar of California experimented with testing lawyering skills on subjects such as interviewing, negotiation and cross examination in the Performance Test portion of the California Bar Examination. The experiment involved applicants orally interacting with mock clients and witnesses and having the applicants' performances evaluated by graders who observed their performances. For various reasons, including questions of validity and reliability, the State Bar has not continued to test applicants based on their oral performances. Instead, the Performance Test portion of the California Bar Examination now consists of written questions regarding subjects such as interviewing and counseling. However, the questions generally focus on applicants' knowledge of applicable substantive law rather than on their clinical skills as an interviewer, counselor or negotiator. Telephone conversation with Dean Barbieri, Director For Examinations for the State Bar of California (July 9, 2003). In finalizing the "Clinical Skills Examination" the National Board of Medical Examiners spent fifteen years and considerable funds "determining how to evaluate clinical skills and devising and objective, fair and reliable test measure. . . ." (http://www.usmle.org/news/cse/csefaqs2503.htm; site last visited on July 11, 2003). Perhaps law school clinicians can get a "leg up" on developing a lawyering skills portion of bar examinations by drawing on the experience of the NBME.

case-centered approach for furthering clinicians' social justice goals, in that clinicians may help produce lawyers who not only understand the problems of the poor but also have greater ability to do something about them.

On the other hand, perhaps clinicians must strike a balance that to some degree favors either education or service. Given that this article is part of a tribute to Gary Bellow's and Bea Moulton's *Lawyering Process* it seems worthwhile to let Gary have the last word on the extent to which clinicians might choose to emphasize education or service. Writing with Earl Johnson in 1971,[104] Gary said the following:

> [I]t is questionable whether service to the unrepresented, despite the enormous need, can be a major function of clinical programs. It is, of course, true that there are incidental services performed to clients in a clinical setting. Certainly, the provision of such services to the poor, who have no alternatives to the service provided, poses special problems of accountability and resource allocation which have not yet been fully recognized. Nevertheless, the need for a work load sufficiently limited to encourage reflection and analysis by the student, the time required to effectively teach in a clinical setting, and the continual turnover of students each semester makes service to clients, even in legal aid clinics, a marginal benefit of such programs at best. A service orientation by clinical programs can too easily become a rationale for permitting law teaching to slip into vocational, how-to-do-it instruction. Where the courthouse is, or how a legal form is to be filled out, can be learned without the commitment of resources, time, or energies that are part of most clinical undertakings.[105]

At the end of the day, clinicians have to weigh competing values and decide for themselves where to strike the balance. We hope that the ideas in this essay become part of the weighing process.

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[104] Earl Johnson is now an Associate Justice of the California Court of Appeal; he has served in that position since 1982. Prior to that time, Justice Johnson served as the Deputy Director and then Director of National OEO Legal Services program and then as a professor of law at the University of Southern California.

[105] *See* Earl Johnson & Gary Bellow, *Reflections on The University of Southern California Clinical Semester,* 44 S. CAL. L. REV. 664, 670-71 (1971). Well, almost the last word.