
Quality-*Lite* for Clinics: Appropriate Accountability within 'Live-Client' Clinical Legal Education.

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Context:

Adrian Evans has run clinical programmes within a community context at Monash University for some time. Students lucky enough to get on the Monash programmes can get credit for their work towards their undergraduate and vocational qualifications. The bureaucracy is minimal. The Monash team train and supervise the students closely to ensure that they know what they are doing and provide a quality service; they discuss the issues which interest them; the staff then grade the students according to the quality of their work for the client, in court or in community development environments. Little time is spent on unnecessary paperwork, since there is already much that must be produced and recorded to comply with legal professional obligations.

In July 2003 *Adrian* invited *Hugh Brayne* to do a mock quality assurance audit on the Monash live-client clinical programmes. *Hugh* brought ten years of experience as an auditor with various English quality bodies, the Quality Assurance Agency, the Higher Education Funding Council, the Law Society and the Bar Council. The English experience has been to specify with more and more apparent precision what an educational programme is designed to achieve, and to claim with more and more precision that the assessment instruments match those achievements, and to involve more and more people in self-monitoring, paper trails and external verification.

Where clinics depend on legal aid franchises, which tend to carry astoundingly onerous bureaucratic requirements designed to nail quality to one centralised regime (well beyond any normal legal professional obligation) – jettisoning that QA regime may not be realistic.

Our paper will explore the tensions. We are not going to be able to jettison quality assurance, even if we wish to. So we will propose a 'quality-lite' agenda for law clinic objectives and student outcomes, asserting that self-governance and our own QA processes will protect live-client clinics

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from ill-designed, externally imposed bureaucratic pressures. Encouragement of innovation in clinical legal education – and its support via *quality-lite* – need not be restricted to a few institutions that are independently funded. Ultimately, QA must be facilitative of development in technique and policy or there will be less and less to ‘assure’, let alone deliver to communities in need.

Introduction

Law centres and law schools combine in various ways to offer legal services to disadvantaged persons and to better educate law students. While these dual educational and public service objectives define and constrain the mix of methods and available outcomes, it is an article of conviction among many involved in live-client clinical education that each needs the other: that education without service is selfish and impoverished and that service without continuous learning is barren.

The view amongst clinicians that their clinics can be effective in achieving both educational and service goals is deeply rooted, but we know we have our critics and detractors. Is a faith-based justification of our effectiveness sufficient? One way in which both sectors – education and legal services – are increasingly called to account for the effectiveness of their work is quality assurance. It is our view that clinics will be increasingly subject to scrutiny for quality assurance purposes, and that the clinic movement should begin to debate how to respond to such demands. But demonstrating that what we consider to be a potent combination of objectives delivers genuine educational and service quality is not straightforward, since conventional quality assurance regimes for both sectors do not ordinarily take account of each other. This article seeks to suggest a number of composite and *appropriate* approaches to educational quality within live-client clinical legal educational settings, and although the issue of service quality is not our focus, it is unavoidable that educational quality assurance will also impact positively on client service quality.

We have not ourselves reached a view whether we should welcome the advent of quality assurance requirements in our clinics, but in a sense that is irrelevant. We have to respond in any event. Thus our primary focus will be on the educational quality assurance aspects, and that is where our own work has started.

Quality assurance in HE

Quality Assurance (QA) is a management tool designed to ensure that products and services achieve uniform *minimum* standards of quality, as a part of the enhanced accountability requirements of modern professionalism.² QA does not inevitably mandate standards as minimums, but the process is as much a psychological one as anything else and the eventual reaction to a standard is to treat it as a minimum.³

2 Steven K Berenson, ‘Is It Time for Lawyer Profiles?’ (2001) 70 *Fordham Law Review* 645.

3 In England, the Quality Assurance Agency for Higher Education has set out subject ‘benchmarks’ for different disciplines, indicating what a student taking a first degree in that subject ought to have achieved. Those for Law can be viewed at <http://www.qaa.ac.uk/crntwork/benchmark/law.html>

In theory the benchmark statements are not mandatory. In practice they are treated as minimum requirements, and to the authors’ knowledge no law degree explicitly departs from them. Additionally the QAA sets generic outcomes for degrees, and each level of study below the award of degree. It is not optional to adhere to these, and quality assurance processes are designed to monitor adherence.

The illusion is that the process is reliable and objective. However it requires assessors to reach conclusions and even gradings which inevitably are the result of judgement.

Despite doubts as to the predictive capacity of a (minimum) standard and who benefits from them,⁴ the technique is entrenched and there is every reason to believe that, where this has not already occurred, compliance with some sort of QA process will shortly impact upon clinical legal education.⁵

QA processes will require, successively, thought about and then documentation of, every stage of the clinical legal education process, sufficient to ensure fairness, transparency in outcomes and the relevant, balanced assessment of results.

So far so good: no one will argue that the above goals are not worthwhile. The problems with the process lie in their psychological effect upon staff and the contribution quality assurance processes make not only to measurement of quality – which is their purported remit – but conceptualization and design of learning and teaching. We know that students focus on what is assessed rather than learning for its own value, and law schools are subject to the same pressures to design and deliver programmes to comply with the assessment which QA brings.

Much of the experience of quality assurance regimes within higher education has been salutary. Teachers who must meet compliance agendas are conscious of the potential for quality reporting to become a deadening influence, devaluing reflection on what might happen and substituting a merely positivist description⁶ – the accuracy of which can often be doubtful – of what has been and gone. Those who design educational programmes to meet quality assurance prescriptions start from external indicators of what their outcomes and objectives should be, and of course they always report that they have then met all of these. A climate of conformity, bureaucracy and even mendacity is, at least potentially, created, though whether professional integrity and effective inspection succeeds in overcoming such pressures is debatable. If we can take the opportunity, as a coherent group of scholars in legal education, to design and implement our own quality assurance processes, we pose the question: what kind of regime is appropriate for legal clinics – their lawyers, their students and their clients? We propose that all might benefit if, in this type of educational programme, indicators of quality can be agreed and, to the extent necessary, formalized which are light on prescription and strong on inspiration.

The limitations of quality assurance processes, once they begin, are that constant change ('improvement') in procedural requirements and the measurement of achievement leads to a lowering of morale, failure to encourage programmes to grow organically, and increased staffing changes⁷. We argue that each of these negatives can be reduced within legal clinics (at least) if those responsible for QA in these workplaces recall why these clinics were established and opt for a

4 *Christine Parker, Just Lawyers, Oxford University Press, Oxford, 1999, pp 22-25*

5 *for example, the Australian national Professional Standards legislation (www.professionalstandards.nsw.gov.au), which is intended to cap liability for negligence in exchange for agreed minimum standards in service delivery, including complaints handling and risk management, will apply to most Australian clinics because their principal solicitors will be bound by these standards*

6 *As John Nelson has commented, 'This is in part because a knowledge of doctrinal law in specific*

curriculum areas is comparatively a more measurable outcome when it comes to demonstrating that accountability standards have been met'. See 12 (2) Legal Education Digest p 10 (October 2003), reviewing Anthony Bradney, Conversations, Choices and Chances: The Liberal Law School in the 21st Century, Hart Publishing 2003

7 *'Inspection fatigue' in schoolteachers in England and Wales is known to the authors as a not uncommon reason for experienced teachers not just to move on but to leave the profession. We are not aware of any data collection in relation to this.*

quality-*lite* approach, preserving the culture of innovation, altruism, mutual respect and systemic advocacy that has attracted highly motivated staff to relatively low paid positions.

Existing QA Norms

Our perspective is informed by the methodology used by the Quality Assurance Agency for Higher Education in England and Wales, which is replicated in many respects by the Bar Council and the Law Society. It may be useful to set out aspects of the current elements:

External examiners. Apart from first year courses at undergraduate level, the setting of assessments and marking of student work is moderated by a senior academic from another institution. This external examiner confirms the appropriateness of the assessment and the marks, that the standards are consistent with the sector norms, and comments on quality issues.

The QAA has specified in detail the requirements for the external examiner and how the University must respond to reports.⁸ The external examiner's reports are used as evidence of quality when the institution or the subject is reviewed by the QAA. From 2004 a summary report confirming the maintenance of standards is also posted on the institution's website.

There is then provision for *peer review of quality*. The peers are external subject specialists, appointed by the QAA as part of a relatively small cadre of reviewers⁹. Evidence for the judgments about quality made by these external reviewers which has to be exercised is then derived from reviewing course documentation; inspecting minutes of relevant school and university committees; sampling assessments; reviewing student feedback and meeting students; checking on internal classroom observation protocols (and if necessary observing classes); talking with staff and stakeholders; and evaluating the *reality* of resources (physical, staffing and financial). Over the past 11 years this process has been applied to all subjects in all higher education institutions, with varying degrees of intensity, ranging from the three day swoop including classroom visits to the 'light touch' adopted more recently, which, through *institutional audit*, involves verifying the institution's own quality assurance processes rather than duplicating them.

In a formal review documentation is the primary source of evidence of quality, and is available to a reviewer in advance and during the evaluation. This would include programme specifications (that is the aims, objectives, and student outcomes for the programme as a whole); individual unit specifications; unit guides; sample assessments; samples of marked work; internal course reviews; minutes of boards of study and assessment boards; external examiner reports; and minutes of staff-student liaison committees. It includes the institution's own assessment of the quality of the relevant programmes, once known as a self-assessment document, but because of the unfortunate but perhaps apt acronym SAD now renamed the self-evaluation document.

No programme of study under this system can be commenced until the course provider has set out, in advance, a statement of learning outcomes for the programme as a whole, and identified where in the programme each of these outcomes will be assessed. This process is known both as validation and course review. It requires learning – knowledge, skill and attribute development – to

8 see UK Code of Practice for External Examiners at <http://www.qaa.ac.uk/public/COP/COPEe/contents.htm>

9 Most of the subject specialists appear to the authors to be in it not for reward but to understand the process so that they can cope when their own provision is inspected.

be broken down into discrete, measurable, and attainable outcome statements which are then parceled out into the various elements of teaching and assessment making up the programme. The quality assurance process will expect the institution then to demonstrate exactly where these outcomes are intended to be, and are in fact, achieved.

All of these measures are well intended, but without exception, they progressively define and measure the social and educational impact of a course or unit as a limited series of numerical assessments or ticks on a checklist. The qualities we described above which we think characterize clinics, and other vibrant aspects of learning culture – imagination, motivation, altruism, respect – do not lend themselves, except in rhetorical and probably hyperbolic contexts, to paper-based measurement. Crucial intangibles such as the sense of vision possessed by the course leader and acknowledged by the staff; the degree of inclusiveness which students feel; the extent to which staff and students act with emotional intelligence in their own working relationships and in their regard for clients; the sophistication of staff ethical awareness and articulation and whether the clinic is making both one-to-one casework and systemic differences to the surrounding community – these are beyond the explicit scope of a typical QA investigation. (They are not necessarily removed from the implicit scope of such enquiry, however, since quality assessors only purport to make objective evidence-based reliable judgements. In fact they are not immune to impression, charm, enthusiasm, idealism etc, and must make evaluations as well as tick boxes. These positive judgements are often made as a result of exposure to the culture of an institution but any final outcome of the quality assurance process denies such influence and spuriously claims that paper-based audit trails supplemented by short and linear interrogation of small numbers of staff and students have captured the relevant information.)

The problem, for those who wish to navigate their educational provision through inspiration and vision as well as objectives and outcomes, is that QA is an unpredictable process. What the quality assurance assessors are looking for is auditable data. While the qualities listed in the previous paragraph, and manifested at any gathering of clinicians, are generally absent from conventional educational quality assurance, we firmly believe that they are the signs of a transcending (clinical) legal education. These are the factors that determine whether the clinic will make a real difference to a student's self-image, to their sense of vocation and to their career choices. In a sense clinicians know that what they do is change people – their outlooks, their futures, their passions. But it would be indulgent and grandiose, not to say demeaning and unrealistic, to reduce such changes into discrete and measurable course outcomes. Then we would have to reduce them to measurable identifiable behaviours that could be assessed.

We can't do that, so we can't be quality assured against such outcomes. What matters and motivates is not actually on the current agenda for quality assurance measurement. If and when the current QA model arrives to measure the achievements of the clinics we value so dearly, what they will measure using available methodologies is restricted to that which we have purported to deliver and assess, which is particular behaviours we want our students to manifest rather than existential change.

Our own experience is that mechanistic quality assurance procedures can result in game playing by academics, supervisors and administrators. To guarantee achievement of stated learning objectives by all students, these objectives may have to be specified at an unnecessarily low level; documents may be produced for quality assurance purposes which do not reflect the reality of what is taught and assessed, or which minute discussions which took place merely for the purpose of creating the

minute; assessments may be produced which purport to assess outcomes which they do not – perhaps cannot – assess; claims may be made as to reliability and equivalence of outcomes and assessments which cannot be justified, and teachers/assessors may knowingly assess according to a holistic and subjective judgment while pretending to be objective; ambitious and meaningful learning may be sacrificed in order to achieve what is quantifiable; meetings on course design, teaching and assessment may concentrate on what is recorded for the purpose of the quality assessment rather than what needs to be freely aired for the purpose of identifying opportunities for improvement and innovation.

Because of the distorting and subversive effect of these now traditional aspects of the quality assurance approach described, we do not place great weight on most of the issues or potential methodologies listed above, in so far as they relate to demonstrating reliability of assessments. In particular, we are sceptical, even to the point of disbelief, that the legitimate desire of government for value-for-money in legal education (via onerous but predictable external assessments) – and legal aid funding (via franchised legal service delivery) – can or will ultimately produce the crucial indicators that distinguish the legal clinic: for example innovation, motivation, excitement, and engagement. But we would suggest that there may be some less onerous approaches to QA which could be considered because of their potential to develop, rather than frustrate, an innovative climate, particularly in clinical legal education.

Quality-Lite Recommendations

This raises the question: should clinics devise and trumpet their own QA processes, including their own version of self and external audit, before these are imposed on us? Our intention is to explore whether we can pre-empt the rather mechanistic UK approaches to quality assurance in higher education, so that they do not devalue the clinical programmes that are now becoming progressively more commonplace in legal education worldwide, and do not degrade the process of inspiring students (and thereby serving the community) by reducing all of what we do to predictable and measurable outcomes.

Even moderate measuring of outcomes against targets, and even a hint of auditing of activities, can reduce creativity and innovation. One of the key achievements of the clinic is one which is rarely stated as an objective, and it focuses on the quality of the working relationships. This, we suggest, rather than a paper-based audit trail, is the key element within a quality-lite approach. In a vibrant programme students seem to find motivation and enjoyment not only in the task, but in the close, almost intense, quality of the relationship with the supervisor and the team.¹⁰ Learning is fostered as much, perhaps more, through mentoring and role modeling as through instruction. This quality of 'modeled trust' dominates our underlying assumptions as to the values of live-client clinics¹¹ and we do, for the sake of clarity, affirm that personal trust among clinic director, supervisors, students and, if this is not obvious, between students and their clients, is both our objective and that trust between the assessors and most or all of these would become the defining mechanism for a quality-lite regime.

10 See generally Hugh Brayne, Richard Grimes and Nigel Duncan, *Clinical Legal Education: Active Learning in Your Law School*, Blackstone, London, 1998

11 We do not wish to imply that there are not further underlying assumptions for clinical work. Shared belief in improving access to justice, in a credible rule

of law and in reasonable social wealth distribution are all a part of the package, but we do not explore these in this paper because that discussion (necessary though it is in other contexts) would divert us from our primary focus of quality assurance.

As we have observed above, quality assurance has, at least in the UK, mainly relied on paper. An audit trail is used to demonstrate that aims match objectives, which are consistent with planned and achieved outcomes. But if we claim that relationships, imagination and engagement characterize the clinical experience, we have a difficult question: how do we measure these? We posit quality-lite assurance mechanisms that obtain data and evidence which cannot be reduced entirely to paper, which depend in part on trust by the auditing authority in its assessors, in trust by assessors in clinical supervisors and in trust of students by their supervisors: in other words, in the respectful, energetic, engagement by assessors in the spirit of the clinic, its supervisors and students. While, of course, paperwork should be of sufficient quality to show, at least, that procedures and expectations have been thought through, we do not expect to find the main evidence on paper that outcomes are met.

Given that QA is – and perhaps rightly – about auditing what goes on against what was intended, as a first step for a quality-lite approach we suggest identifying some of the key characteristics of what in our view makes clinics valuable. Then we have to suggest some possible auditable indicators of achievement.

At this point in our thinking we would like to explore a two-stage process for identifying this quality-lite process. First we flag those qualities of clinical objectives and student outcomes, which we consider are essential elements of a viable and creative clinical programme. Secondly, in relation to each of these qualities, we try to demonstrate some of the relevant and valid quality-*lite* things to do, to assure the delivery of both objectives and outcomes. We will also briefly mention some of the things to avoid doing, in trying to achieve these objectives and outcomes. Our proposals, which are spelled out in the table below, are tentative and consultative: we seek the evaluation, advice and judgement of readers and clinicians, and would like our ideas to be judged on their capacity to assure and nurture the forward-thinking inspirational approach, rather than recite and prescribe monochrome content.

Qualities of the Clinic	Qualities Encouraged in the Student	Demonstrating these with Quality-Lite
Creativity in programme objectives and organisation	Creativity of student responses to client dilemmas.	Ask <ul style="list-style-type: none"> • Does acknowledgment of creativity figure in supervisor feedback to students during supervision and following assessment? • Is there an energy/frisson visible in student-supervisor conversations, in out-of-hours activity as well as scheduled activity and in student evangelism in the wider law school? • Is there evidence of the supervisors exploring with the student whether unrealistic ideas were based on imaginative conceptualization of the problem, or merely because of failure to grasp essential detail?
Inwardly and outwardly focused ethic of clinic reflection on its own vision and processes	Students' <i>reflections</i> on <ul style="list-style-type: none"> • the extent of clinical legal services users' autonomy • understanding of how legal services meet the needs of the community or not, in the case of specific clients, and why this might be the case 	Ask if there is evidence of critical and reflective analysis <ul style="list-style-type: none"> • within reflective journals • in staff publications • in supervisor discussion with students • within staff meetings • in written campaign strategies • in submissions on law reform issues • in community development plans and strategy documents • in funding submissions?

Qualities of the Clinic	Qualities Encouraged in the Student	Demonstrating these with Quality-Lite
<p>Clinic policy on contemporaneous client intake related <i>supervisor-student discussion of the immediate clinical experience</i>, having regard to the above quality-lite indicators</p>	<p>Habituated, student <i>discussion</i> with each other and their supervisors, concerning immediate client needs</p>	<p>Ask Is/are there</p> <ul style="list-style-type: none"> • Facilitated meetings among supervisors and students, held close in time to relevant client intake sessions? • A process for students to provide their own views as to the quality-lite approach? • A list or statement for the student of the ideals of the clinic and what is hoped it will do for them? • Evaluations within student journals of what has happened to them in relation to each of the above ideals?
<p>Clinic <i>confidence</i> in its processes and outcomes</p>	<p>Student confidence in their personal and professional development as a consequence of participation in clinical process</p>	<p>Ask</p> <ul style="list-style-type: none"> • what the policy documents, submissions and annual reports of the clinic indicate about clinic confidence in its contribution to legal education • what clinical students say about their own experience of the clinic? • what other law students report about what the clinic gives to its students
<p><i>Interdisciplinary</i> focus of clinic operations – to achieve 'whole of problem' approaches re systemic injustice and individual client satisfaction.</p>	<p>Students' <i>interdisciplinary</i> process in dealing with clients' work – including recognition of non-legal dimensions of clients' problems.</p>	<p>Ask</p> <ul style="list-style-type: none"> • Do students record in journals, their wholistic assessment of the client's needs and possible 'solutions'? • Do teaching materials evidence interdisciplinary awareness and approach? • What are the opinions of related agencies? • What is revealed in conversation with students?

Qualities of the Clinic	Qualities Encouraged in the Student	Demonstrating these with Quality-Lite
Clinic development and engagement with <i>normative</i> community development and law reform possibilities	Student engagement with <i>normative</i> community development and law reform models	Ask For examples of current client case plans containing an element of the socio-legal story around each client's dilemma. Ask community partners for their opinions. Consider if broader community objectives are present in teaching materials and in student conversations.
Clinical policy and practice re <i>ethical</i> behaviour in relation to clinic administration & student-client interaction	Student self-awareness of their own personal values, of the various <i>ethical</i> methods which apply to legal practice and of the method which most appeals to them	Ask if <ul style="list-style-type: none"> • Student reflective journals demonstrate self-awareness of alternative ethical models and of any relevant ethical choice they intend to make? • Students have only a consciousness of conduct rules? • Supervisors' journals articulate first principled-ethical consciousness?
Clinic <i>attitudes</i> to <ul style="list-style-type: none"> • interest in the client as a person rather than as a case, • collaboration between co-students and • staff/student reliability in deadlines/meetings 	Student <i>attitudes</i> to <ul style="list-style-type: none"> • interest in the client as a person, • working with fellow students and • punctuality and reliability in achieving deadlines 	Ask <ul style="list-style-type: none"> • Does the client case plan show client respect, or only interest in point(s) of law? • Is the student comfortable with team work? • How effective is the students' diary system?
Clinical policy in relation to development of the range of <i>students' technical skills</i> and doctrinal awareness	Student respect for <i>technical competency</i> , diligence in legal research and effective client communication	Ask if <ul style="list-style-type: none"> • Client case files evidence technical skill, an accurate (normative) knowledge of the law and good client communication • Students' journals display awareness of the range of technical skills necessary to competent legal practice • Client feedback via satisfaction surveys supports students' technical competence

Qualities of the Clinic	Qualities Encouraged in the Student	Demonstrating these with Quality-Lite
<p>Clinic expectations of supervisors' accountability re students' achievements (as described above), to</p> <ul style="list-style-type: none"> • promote consistency between supervisors • satisfy Faculty concern that clinical marks are too high compared to mainstream assessment • safeguard against complaint of bias or unfairness • allow sharing of assessment with colleagues delivering other parts of the students' course programme • allow legal, ethical and procedural issues arising from client work to be identified and recorded for regular discussion, staff development activities and analysis leading to publication. 		<p>Ask</p> <ul style="list-style-type: none"> • Do supervisors maintain work journals recording student achievements? • Do supervisors share the contents of their work journals and opinions of individual student performance with each other? • Do supervisors publish jointly and/or in conjunction with non-clinical academics? • Do supervisors meet formally or informally over meals and use some of this time to reflect on clinical policy and/or students' progress? • Are there mechanisms for training and developing supervisors' knowledge base, skills and awareness of clinical policy?

These suggested qualities of creativity, reflection, confidence, collaboration, a normative understanding of law, ethical choice and teacher-learner accountability would be at the heart of quality-*lite* assurance. We admit that these suggestions mix the subjective with the objective assessment of performance; and we opt for a modest compromise of indicators which promote cohesion, collaboration, insight and commitment amongst clinical staff and students. They also encourage a role for quality assurance assessors which it is our experience that many in the UK have indicated a yearning for – the ability to play the role of critical friend rather than conveyor of judgment. In the end, teaching and supervising – indeed any professional function – cannot be reduced in a quality-*lite* context to a total objectivity because the professional function, not just the environment of the successful clinic, demands trust of the clinical practitioner and of their judgment.¹² Such trust and judgment involves acceptance of some subjective elements in QA and ideally, a compromise in approach as to what is measured. We believe that trust and the building of relationship between assessor and their clinicians is in itself a valuable goal, and strengthens and even validates the exercise of judgment. A quality-*lite* process does not falsely pretend to achieve objectivity where subjective elements must and do contribute to judgment.

¹² See Onora O'Neill, 'A Question of Trust', Reith Lectures, BBC 2002

Things a quality-lite approach seeks to avoid

Inevitably, there are some QA approaches which we think are unlikely to promote quality-lite trust but will lead to a reductionist atmosphere developing within the clinic. The following would, in the measurement, possibly serve to destroy what would be measured:

- exhaustive listing of case information and case variables on all sampled case files
- mechanistic scoring on a card (or via software) of the possible indicators for creativity,
- names and numbers of interdisciplinary services/agencies which were accessed in dealing with client problems,
- insistence on written reports from any such agencies to evidence their involvement, the areas of client welfare other than law listed by the student on the client record,
- checklists to record whether for example there are written instructions on file from the client to commence proceedings, whether there was an interpreter present in all discussions with the client, whether the students produced interviewed in accordance with predetermined client interaction protocols.

Such strategies do not even offer short-term reassurance to assessors, are of next to no use to the clinic *per se* and promote, among staff and students, merely positivist recitations of events and actions. The normative practice of law recedes in importance as the volume of checklists expands.

Restricting QA assessments to what can be repeated and externally verified, as in the related legal aid franchise environment, reduces considerably the quantity of evidence on which such assessments can be based, omitting in particular the evidence derived from regular and detailed observations of student performance. It is possible to replicate this evidence, as we suggest above, by requiring students to report, for assessment purposes rather than as a normal part of their case management, in writing on their activities under specified headings. Reporting can permit evaluation of the additional outcomes we value, such as critical evaluation or personal insights into learning. However – and this is where a link to service quality is unmistakable – a student whose service delivery is poor has to be tentatively assessed more encouragingly if the account of that service delivery and the reflection on learning is good; or vice versa.

To the extent that educational quality assurance can gain a ‘quality’ lead over other QA processes, such as franchised delivery and professional risk management regimes, the quality high ground may be retained. With so many commentators now proclaiming clinical method as *the* way out of merely positivist legal education,¹³ there is much at stake if student creativity, innovation and emotional commitment to normative learning is not to be sterilised to fit ‘objective minimums’.

13 Robert Gordon of Yale University, is one of many who advocates more linked ‘clinical-ethics’ initiatives in law schools, because of their potential to actively develop a critical morality in future lawyers. See Keynote Address, First International Legal Ethics Conference, Exeter University – July 2004

Conclusion

Heavy-handed, mechanistic approaches to QA such as those commonly used in the current UK protocols are most unlikely to assist a comprehensive understanding, let alone improvement, of clinical legal education in the UK and Australia. In the spirit of creativity which we see as normal in the viable clinic, supervisors ought to see quality-*lite* assurance as a process of ongoing informal peer review; as developmental rather than as onerous; and as encouraging of innovation in all aspects of its operation.

While QA necessarily involves some 'adding-up' – at least in verifying the existence of procedures – it is the existence of good working relationships, of creativity in both approach and solution, of encouragement to critically reflect on the justice system, of experimentation in approach to problem solving, of value-centered ethics and of positive student attitudes to clients and to their fellow students, that are at the heart of valuable QA in clinical legal education.

** Quality-lite assurance in clinical legal education is not yet a formal reality and its detail is likely to vary between jurisdictions and cultures. The effort commenced here to argue for such a regime and to suggest some appropriate assurances, has barely begun. Clinics have too much to offer both disillusioned and doctrinally-focussed law students, for that effort not to be continued.

The 2003 informal review of the Monash clinics provide an anecdotal glimpse into what is possible in quality-*lite* assurance. This review was conducted over about two and a half weeks, from start to finish. The emphasis of the review report was upon trusting assessment, not fault-finding, though it became clear that there were issues which needed to be addressed. When, in early 2004, the new Dean of the law school asked if it was necessary to do a formal review of the clinical programme, the answer was that the clinical staff had had – in the spirit of creative development – much input to the informal review, its recommendations had met with general agreement, assessment sub-committees had commenced improvements and, incidentally, the report was available for him to peruse.