
An Examination of the Challenges, Successes and Setbacks for Clinical Legal Education in Eastern Europe

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I. Introduction

The authors first met in 2000, and have collaborated in conferences, workshops, and other projects since then. We also represent two sides of an international exchange that has frequently occurred in the past 15 years: a European law teacher who attends training sessions, networks with colleagues from other European universities, learns about American models of clinical education, and possibly receives some outside funding; and an American law teacher who is graciously hosted by Europeans, promotes American models of clinical education, and, one hopes, observes, listens and learns about the European system. We are also experienced teachers within our own universities and teach both clinics and more doctrinal courses. Finally we are friends and can be honest with each other.

After more than 10 years of working together, we wanted to take stock of the collaboration between American and European academics on issues of clinical education. We wanted to take a close look at what has happened in Central and Eastern Europe since the first “American invasion” of U.S. consultants and funding: what clinical programs were developed? Which ones survived after the consultants and funding left? Why did some programs survive and prosper, while others disappeared? What do the surviving models look like?

We also wanted to ask a series of more subjective and potentially sensitive questions: was the American influence ultimately helpful and productive? To the extent that it was *not* helpful, what have we learned about improving such cross-cultural international collaborations in the future? Have European law schools copied US models of clinical legal education, or have they developed

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their own models?

In the following sections we first discuss the history of clinical legal education in Central and Eastern Europe. We then focus on Croatia and Olomouc, Czech Republic, two examples of the ambitious but uneven development of clinical programs in Central and Eastern Europe. We next examine the experiences of clinical programs in countries of CEE and some of the challenges these programs have faced in achieving sustainability. We then use a comparison between the European and U.S. clinical program models as a lens for analyzing the experiences of the European programs and assessing the value of collaboration between European and U.S. clinical teachers. Finally, we offer some thoughts about the future of clinical legal education in Central and Eastern Europe.

II. History and Overview of Clinical Legal Education (CLE) in Central and Eastern European (CEE) Countries

Clinical legal education in Central and Eastern European countries emerged in the second half of 1990's. It first started on an experimental basis but in time it became an integral part of higher education programs in a number of these countries.³

According to different sources, in only a few years, from 1990 until 1995, more than 100 clinical programs were established in the countries of CEE, including many in Russia⁴. Clinical legal education was recognized by law schools in the region as a teaching and learning method that actually prepared students to practice law. Further, the clinical method of learning – learning by doing – was a “breath of fresh air” in the otherwise typical atmosphere of the “classical” classroom lecture methods applied in most law schools in Eastern and Western Europe⁵.

As discussed below, however, the development of CLE in Europe has been far from uniform. There are significant differences between CEE and Western Europe, as well as among the countries of CEE.

A. East v. West: CLE's Growth in CEE Countries and Its Failure to Take Hold in Western Europe

While Central and Eastern European countries accepted CLE with lots of enthusiasm, Western European countries were resistant to innovations involving the implementation of CLE⁶. Only a few clinical law programs have been established so far in Western European countries, notably in

3 For a comprehensive discussion of the history of CLE in Europe, see Edwin Rekosh, *Constructing Public Interest Law: Transnational Collaboration and Exchange in Central and Eastern Europe*, 13 UCLA J. Int'l L. & For. Aff. 55, 83-92 (2008).

4 Lusine Hovhannisian, *Clinical Legal Education and the Bologna Process*, PILI Papers, No. 2, December 2006., pp.14; Richard Wilson, *Western Europe: Last Holdout in the Worldwide Acceptance of Clinical Legal Education*, 10 German Law Journal 825 (2009).

5 Wilson, *supra* note 2, at 825-28.

6 *Id.* at 828.

the UK⁷. (This is quite understandable due to the fact that it is a common law country.) Besides the UK, successful clinical programs have been established in Spain, the Netherlands⁸ and one of the most developed is in Norway⁹. In France¹⁰, Germany¹¹ and Italy¹² CLE programs exist in only a few law schools.

This situation provokes the question: why has CLE been so well accepted in the European East and not so well in the European West? We want to suggest a few reasons.

First, all Central and Eastern European countries faced the fall of communism, which resulted in a high level of incentives to change things. In this context, and as said before, CLE was a “breath of fresh air” in the otherwise typical atmosphere of the “classical” classroom lecture methods applied in most law schools in Central and Eastern Europe.

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- 7 See James Marson, Adam Wilson, & Mark Van Hoorebeek *The Necessity of Clinical Legal Education in University Law Schools: A UK Perspective*, 7 *International Journal of Clinical Legal Education*, 29-43 (2005); Richard Grimes, *Legal Literacy, Community Empowerment and Law Schools – Some Lessons from a Working Model in the UK*, 37 *The Law Teacher* 273 (2003); Julian Webb, *Inventing the Good: A Prospectus for Clinical Education and the Teaching of Legal Ethics in England*, 30 *The Law Teacher* 270 (1996); Nigel Duncan, *Why Legal Skills – Whither Legal Education?*, 25 *The Law Teacher* 142 (1991); see also Model Standards for Live-Client Clinics A Clinical Legal Education Organisation (CLEO)* Document (updated 2007) (available at: <http://78.158.56.101/archive/law/files/downloads/38/713.83471086.standards.rtf>); *Moving On: New Initiatives, New Resources: Report on the 2002 CLEO Conference* (available at: <http://www.ukcle.ac.uk/resources/teaching-and-learning-practices/2002conf/>)
 - 8 See <http://www.uu.nl/faculty/leg/en/organisation/schools/schooloflaw/organisation/departments/studieeninformatiecentrummenserechten/cp/Pages/default.aspx?refer=/legalclinic>
 - 9 See Jon T. Johnsen, *Nordic Legal Aid*, 5 *Md. J. Contemp. Legal Issues* 301, 328 (1994); see also Jon T. Johnsen, *Juss-Buss and Clinical Legal Education* (University of Oslo, 1991).
 - 10 See, e.g., <http://master.sciences-po.fr/droit/en/content/access-justice> (Law Clinic of the Sciences Po Paris Law School); <http://www.unicaen.fr/recherche/mrsh/crdfed> (Fundamental Rights Law Clinic of the University of Caen); and <http://ufr-dsp.u-paris10.fr/ufr-de-droit-et-science-politique-dsp-/etudiants/euclid-386003.kjsp?STNAV=&RUBNAV=&RH=1314308994710> (Euclid Law Clinic of the University Paris Ouest Nanterre).
 - 11 Few legal clinics exist in Germany, at least in part due to the rigidity of Germany’s higher education laws. See Andreas Bucker & William A. Woodruff, *The Bologna Process and German Legal Education: Developing Professional Competence through Clinical Experiences*, 9 *German Law Journal* 575, 611-13 (2008) (discussing rigidity of German law of higher education as an impediment to establishing clinics in German law faculties). Among those universities that do have clinics are the Hochschule Wismar, which has established a live client clinic for Master degree students, see *id.*; the [Heinrich-Heine-University Düsseldorf](http://www.jura.hhu.de/en/hilfe.html) Faculty of Law, which offers a legal advice clinic, see <http://www.jura.hhu.de/en/hilfe.html>; and Humboldt University, which has a human rights clinic. See <http://baer.rewi.hu-berlin.de/eng/humboldt-law-clinic>.
 - 12 In February 2012, the University of Brescia organized an international conference on clinical legal education in Europe. See <http://www.lider-lab.sssup.it/lider/attachments/article/25/LocandinaClinicsDEF.pdf>. Four Italian legal clinics presented their work and discussed their models of clinical legal education. Those are the legal clinics from Turin, Rome, Florence, and Brescia (the host of the conference).

Second, all Central and Eastern European markets went through transition. So there was a strong demand from market forces for reforms and legal reforms in particular.

Third, the transformation, from a non-market to a market economy model, led to an increased need for free legal aid. A number of Central and Eastern European countries faced massive bankruptcies, lots of people were jobless, and some countries, like Croatia, were struck by war. Due to all of these factors, there was an increased demand to help the people in need, but the inherited model of free legal aid could not satisfy all of these needs. Civil societies institutions, who are currently also important free legal aid providers in CEE countries only started to develop at the time.

And finally, there was a whole new generation of law students who wanted change. They demanded more from legal education than faculties had previously provided for them.

B. Different Models of CLE in CEE countries

In addition to the different developments of CLE in CEE and Western Europe, there have been significant variations among the countries of CEE. Despite the fact that CLE appeared at the about same time throughout CEE, it did not follow the same pattern. What we notice, while exploring developments in CLE in different Central and Eastern European countries are peculiarities of CLE. Each country, and even the law schools within one country, have developed different models of CLE. While some countries and law schools unanimously chose the model of live client clinics, others accepted simulation clinics or the placement model (“externships”). This was surprising if we have in mind the fact that CLE in CEE was shaped and modeled with the help or assistance of no more than three U.S. partners, PILnet (formerly PILI), the Soros Foundation, and ABA CEELI¹³, and all of these funders specifically promoted the live client model.

The same phenomenon occurred in the context of clinical subject matter. Different types of clinics were established: constitutional law clinics, criminal law clinics, environmental clinics, business law etc. However, this is perhaps less surprising because the U.S. funders did not focus on any particular subject matter in the models they introduced.

This leads to several questions: given that these clinical programs were all based on similar U.S. models and benefitted from the same training and capacity-building efforts, why was a uniform model of CLE not accepted or developed in CEE? Is this diversity of models good or bad for CLE in CEE countries? What are the reasons for this diversity of CLE models?

There are several possible answers:

- a) The design of clinical programs often reflected the particular persons who conceived and developed a particular program. It was usually a particular person within the law school, not the law school as an institution, who created the clinical program.
- b) Clinical design was often regionally or geographically related. Different Central and Eastern European countries were burdened with different problems, and these were reflected in clinical activities. For example, while some countries had an increased need for labor law clinics, others had a need for refugee clinics.

13 See Leah Wortham, *Aiding Clinical Legal Education Abroad: What Can Be Gained and the Learning Curve on How to Do So Effectively*, 12 *Clinical L.Rev.* 601 (2006).

c) There was also a lack of systematic approaches and strategies towards a more uniform concept of CLE in CEE. Even clinics within a single country did not cooperate on curricular development or clinical pedagogy or other aspects of clinic design. So the clinical movement in CEE in the 1990's can be, to some extent, characterized as an *ad hoc* approach. As discussed below, this might be the reason why a number of clinical programs failed within a short time.

III. Specific Examples: Croatia and Olomouc, Czech Republic

To provide illustrations of some of the general descriptions and conclusions presented above, we offer examples from Croatia and the Czech Republic. These are two countries with which we have experience, the European as a direct faculty participant and the American as an visitor and observer.

A. The Croatian Example: Four Schools, Four Different Experiences

CLE in Croatia has a short tradition. It started later than in other parts of CEE due to the fact that the country was at war. Therefore transition came somewhat later.

The first Croatian clinical program started at the Faculty of Law in Rijeka in 2002, following by the legal clinic established at the Faculties of Law in Osijek in 2003 and in Split in 2008. In 2010, a live client clinic was established at the Faculty of Law in Zagreb. The establishment of a legal clinic at the country's oldest university was actually a major breakthrough for the future of CLE in Croatia¹⁴.

Clinical programs in Croatia were, from the very beginning, recognized and well accepted by legal academics as a new teaching methodology which can enhance legal education. In a short time clinical programs became a part of the mandatory curricula at all four law schools, although clinical programs are carried out in each of the law schools in different ways.

The legal clinic established at the Faculty of Law in Zagreb is the country's only live client clinic. Other law schools apply the models of either simulation or placements.

Despite intensive clinical activity and affirmation of clinical programs as an accepted teaching methodology, clinical development in Croatia has not been without problems, some examples of which are particularly visible in the smaller law schools which are not located in the capital city. These problems are similar to those mentioned above.

They can be summarized as follows:

a) Staffing problems

Smaller law schools have a small staffing capacity. The situation is much better in the capital city.

b) Problems with practicing lawyers in smaller cities

14 See Barbara Preložnjak, *Clinical Legal Education in Croatia – From Providing Legal Assistance to the Poor to the Practical Education of Students*, 10th International Journal of Clinical Legal Education Conference, Durham, UK, July 2012. (unpublished paper; English-language abstract available at http://www.numyspace.co.uk/~unnmlif1/school_of_law/IJCLE/abstracts.html); See also: <http://klinika.pravo.unizg.hr/> (in Croatian).

In many CEE countries, including Croatia, clinics must hire private lawyers to supervise law students in the legal work they perform, because law professors are often not permitted to be practicing lawyers. Finding and keeping involved a practicing lawyer on a stable basis is quite hard in smaller and poorer environments. Besides that, lawyers have poor or no knowledge of clinical pedagogy and methodology, which creates additional problems.

c) Ad hoc approach to organizing CLE

Clinical activity in Croatian law faculties depends too much on one person. Faculties are not involved enough to take over the responsibility and incentive for clinical development.

d) Lack of teaching credit for clinical faculty

Since clinical programs are new, clinical teachers often get no credit for performing CLE. It is purely voluntarily engagement, which must be performed in addition to all of the other demands (heavy teaching responsibilities, Ph.D. studies, administrative duties) placed upon the faculty members who teach clinics.

e) Legislative restrictions

Until 2008, Croatia had an additional problem. It was not clear what kind of legal aid clinics could perform. This issue was clarified to some extent in 2008, when the Code on free legal aid¹⁵ was enacted.

B. Olomouc, Czech Republic – the Flight of the Phoenix

The first live client legal clinic in Central Europe was at Palacký University, Olomouc, Czech Republic. It was funded by the Ford Foundation in 1995-1997¹⁶. However, this clinic was also one of the early failures, ending as soon as the outside funding stopped. Edwin Rekosh explains some of the reasons for this: “Arguably, those instances of failure were caused by some of the phenomena implicit in the pure export model; they were not sufficiently adapted to local conditions by locally-based champions working (when helpful) in long-term collaborative relationships with foreign partners.”¹⁷ Rekosh goes on to discuss the demise of the Olomouc clinic:

Certainly, this was the case with the initial experiment at Palacký University in the Czech Republic supported by the Ford Foundation. The initial local champion of the project, who had been dean of the law school at the time, passed away. The clinic director that his successor had appointed to run the project, a local bar advocate, treated her position supervising the students in the “live-client” clinic as an ordinary job and had no vision for or interest in what the clinic might become The foreign partner in the project interpreted the deficiencies of the start-up initiative as stemming from a lack of commitment by the local partner to core public interest values.¹⁸ Rekosh concludes that these problems were not limited to Olomouc: “No doubt many of

15 Official Journal No. 62/08 and 81/11

16 See Rekosh, *supra* note 3, at 87 n. 98.

17 *Id.* at 88-89.

18 *Id.* at 89, n.102.

the initial clinical projects supported by foreign donors were seen even more cynically by local actors as vehicles for bringing in much needed financing to resource-strapped state universities.”¹⁹

And yet, after this initial failure, the Olomouc clinic has since come back to life stronger than ever, with several different clinics, many of which are live client models, as well as an introductory lawyering skills simulation course, classes on legal ethics, and an energetic and innovative teaching staff who participate actively in international conferences.²⁰

IV. Evaluating the Experiences of Clinical Programs in CEE: Common Problems Which Different Clinical Programs in CEE Countries Have Faced

The experiences in Croatia and the Czech Republic provide examples of some of the challenges facing CLE in CEE, as well as the possibilities for overcoming these to develop strong and sustainable programs. Evaluated in general, and from a distance in time of some 15 years, the CLE programs that started in CEE in the 1990’s were a great success. This is especially true in Poland, which is the “gold standard” for European clinical education programs. Law clinics exist in law faculties throughout Poland, and clinical faculty meet in national and regional conferences. In addition, clinical educators in Poland have developed an extensive set of materials to support CLE.²¹

But the success has been uneven. The authors have attended many clinical teaching conferences in CEE and have observed that after a successful beginning, a number of clinics faced failure within a short period of time. On the other hand, a number of other clinics, established at the same time and in similar circumstances, experienced great success. This situation again raised the question: why do some clinics tend to be very successful and other clinics fail?

The exact reasons are unknown because there is no study which tracks the various clinics that were started in the 1990’s and shows how many of these clinics have been closed. But most of the available information suggests the following problems which are common to many clinics which faced failure:

19 *Id.*

20 To take one example – in 2011, law teachers from six continents gathered in Valencia, Spain, for the Global Alliance for Justice Education Worldwide Conference. At that conference, four of the sessions were conducted by members of the faculty at Palacký University. This only underscores the leadership position of this institution and faculty in international legal education reform.

21 For a description of law clinics in Poland, see Joanna Sliwa, *Report on the Legal Education in Poland* (Pilnet 2010), 23-25, available at: http://www.pilnet.org/component/docman/doc_download/45-legal-education-in-poland-building-institutional-will-for.html. See also, Rekosh, *supra* note 3, at 90-92.

a) *Funding*

Loss of outside funding frequently resulted in decreased clinical activities. Many law faculties were not prepared to take over funding responsibilities once foreign funders withdrew.

b) *Staffing problems*

It is very typical for CEE law schools to have too many students compared to the number of teaching staff. This also caused problems in the context of clinical education. There were often too few university teachers who could participate in student supervision and assessment.

c) *Legislative barriers*

Within the universities of CEE there is a wide lack of support and incentives to make the necessary legislative changes to the educational process that would create a system in which CLE is a presumed component of the law curriculum.

V. Comparisons Between the European and U.S. Experiences

In examining this uneven history of CLE in Europe, it is useful to compare the European programs with those in the U.S.²² As noted above, start-up funding for the European programs was provided by U.S. donor organizations, and much of the technical support and training was provided by U.S. educators. The U.S. has a 40 year history of CLE, and many of the European programs were based on successful U.S. models. Why, then, have the results been so mixed?

This question prompted an engaging and enlightening dialogue between the authors. We have observed that although the Bologna Process is moving the European system of law and legal education closer to that in the U.S.²³, the fundamental historical and cultural differences between the civil and common law systems continue to have an effect.²⁴ In Europe, CLE – and interactive education more generally – has to be incorporated into the prevailing, traditional, lecture-based doctrinal model of education.

The challenge is not in adding clinics formally to this traditional curriculum. In most CEE countries, clinics *are*, in fact, part of the curriculum, because the relevant governing educational body would not otherwise allow them to be taught. In Croatia, for example, if a faculty wants to teach a legal clinic, the faculty must write a detailed proposal for the clinical course and seek formal approval from the governing body. This is true of other CEE countries as well, because public universities are the prevailing model.

22 For general comparative discussions, see Leah Wortham, *Aiding Clinical Legal Education Abroad: What Can Be Gained and the Learning Curve on How to Do So Effectively*, *supra* note 13; Lee Dexter Schnasi, *Globalizing: Clinical Legal Education: Successful Under-Developed Country Experiences*, 6 T.M. Cooley J.Prac. & Clinical L. 129 (2003); Frank S. Bloch, *Access to Justice and the Global Clinical Movement*, 28 J.L.& Pol'y 111 (2008).

23 See Laurel S. Terry, *The Bologna Process and Its implications for U.S. Legal Education*, 57 Journal of Legal Education 237 (2007).

24 For a discussion of the differences between the civil and common law systems and the effects of these differences on CLE, see Philip M. Genty, *Overcoming Cultural Blindness in International Clinical Collaboration: The Divide Between Civil and Common Law Cultures and Its Implications for Clinical Education*, 15 Clinical L. Rev. 131 (Fall 2008).

Therefore incorporating clinics within the CEE curriculum is not the primary obstacle to be overcome; rather the challenge to successful implementation of CLE in the region is that clinics lack respect from the majority of law professors, who are traditional in their views and resistant to change. They generally oppose curricular reform, particularly with respect to educational content and teaching styles.

A related challenge in Europe is an underdeveloped clinical pedagogy and the lack of a clear curricular design. Students often do not receive academic credit for their work, and clinical seminars frequently operate without a set curriculum, syllabus, or teaching materials specifically designed for clinical courses. It will take time to develop clinical pedagogy in Europe. It appears that only Poland has managed to do that to some extent.

One area in which the U.S. has a clear advantage over most European countries is that the U.S. curriculum is more flexible. Because the courses in the U.S. common law system are not typically compulsory after the first year, course offerings and teaching methods tend to be fluid and varied. Thus, there is room in the curriculum for clinical courses, offered for many credits ($\frac{1}{2}$ of a student's total semester credits is common), with an extensive syllabus, ambitious curriculum, and well-developed materials, sometimes including textbooks specifically designed for these programs. The American clinical course is therefore a complete "package" of substance, skills, values, and experiences. This is not generally true of European clinics, because the time and space for clinics needs to be "borrowed" from other parts of a set, formal curriculum. European students therefore get only part of this educational "package" in the clinics they are able to take.

There are at least six, less fundamental, differences between the European and U.S. experiences with CLE. First, there are still relatively few live client clinics in European universities²⁵. Is it important that clinics have live clients, or are interactive simulations and project-based clinics equally valuable in the European educational context? Much of this is a function of sheer numbers of students. Even in universities with live client clinics, demand tends to exceed available opportunities even more than in the U.S. because of larger class sizes. For example, in Osijek, Croatia, a small school, three instructors in one academic department are responsible for giving lectures, examinations, etc. to 1,200 4th year students.

Second, the legal assistance provided to clients in European clinics tends to be shorter term than in the U.S., with a focus on the one-time giving of advice or drafting of legal pleadings or other documents. In this way European clinics resemble some limited scope "unbundled" *pro bono* programs in the U.S. One practical reason for this is the length of court proceedings. Even the simplest cases usually last longer than an academic year, and students do not want to continue their involvement beyond the academic year.

Third, among the most interesting differences we examined is the focus of the clinics in the two systems. European clinics tend to focus less than U.S. clinics on the dynamics of the attorney-client relationship, including interviewing and counseling skills and developing a relationship of empathy with the client. The focus in European clinics might be described as being more on "solving the case" than "understanding the client."

²⁵ There are no reliable data about the number of legal clinics in Europe in general, and in particular about the breakdown among types of clinics, e.g. the number of live client clinics. Perhaps this situation will improve with the establishment of ENCLE (European Network for Clinical Legal Education). See: http://www.uc3m.es/portal/page/portal/instituto_derechos_humanos/sala_prensa/comunicados_de_prensa/encl.pdf.

Solving cases rather than getting to know the client is not specific to the clinics, however – it is the typical approach of practicing European lawyers. In other words the clinics are reflecting actual practice, which is arguably what they should be doing.

This observation has significant implications for cross-cultural work. Many of the clinical training sessions provided by PILnet, ABA-CEELI, and other U.S. organizations for European law teachers have focused extensively on teaching interviewing and counseling skills on the theory that these skills are essential to effective lawyering. However, it may be that these skills are relatively unimportant in European law practice and that a focus on these skills in clinical development work is therefore misplaced. The European author's own experiences appear to support this conclusion; she noted that she had found this aspect of the training sessions she had attended relatively unhelpful.

Fourth, related to this lack of focus on the attorney-client relationship, education in ethical issues is not typically part of the European clinical curriculum (but it is not part of the non-clinical curriculum either). Where ethics courses exist, they tend to be taught in a code-centered lecture format, rather than the interactive problem-based model that is more common in the U.S. Palacký University in Olomouc, Czech Republic is an exception, because it offers an elective, interactive ethics course, which is taught by one of the clinical faculty members. This course is beginning to be replicated in other Czech universities.

Fifth, in some European countries, especially those in which professors are not allowed to practice law, clinics must contract with practitioners for court representation of clients. There may be an educational gap for the students if the practitioners are not trained in clinical pedagogy and included in faculty discussions of such pedagogy.

Sixth, European countries do not generally allow for student practice in courts and administrative proceedings. (The Republic of Georgia is one exception to this.) Related to this, it is not clear to what extent attorney-client confidentiality applies to law students who meet with clients in law school clinical programs.

All of these differences need to be taken into account in structuring effective collaboration between European and U.S. colleagues. As discussed below, future collaborations should focus more on supporting the new European models of clinical education rather than replicating U.S. models.

VI. Reflections About the Future of Clinical Legal Education in Central and Eastern Europe

After the first wave of funding and consultants ended, many European clinical programs did not survive, suggesting that clinical education might not be sustainable in the long-run without outside funding. However, the good news is that the support provided in the 1990's and 2000's by outside organizations (Ford Foundation, ABA, OSI, PILnet, etc.) planted seeds of "human capital" – the law teachers and students who attended the conferences and workshops have become an energetic new generation of clinical educators. In addition, Bologna and other European educational reforms have stimulated the introduction of graduate law programs. These graduate students – especially Ph.D. students – are often themselves products of the new clinical education programs, and they have taken on important teaching roles within the clinical programs. This "human capital" may ultimately be a more important factor than outside funding in achieving sustainability for clinical

education in Europe.

However, in thinking about the future it is important to distinguish among three main goals of CLE and tensions among them. Clinical scholars typically identify the following goals: creating social change by giving disadvantaged groups access to legal services; making experiential courses mandatory so that all students are better prepared for the profession they will be entering; and providing students with a “live client” experience.

It is hard, if not impossible, to do all three of these things in existing European systems, and it may not be realistic to think that all three goals can be achieved. Live client clinics require a lot of resources, so they will have to be limited to a small number of students. It is probably more realistic to offer simulation clinics, which can be provided to larger number of students. To the extent that live client opportunities are offered, the best way to give the largest number of students this opportunity is to give them short-term cases involving limited scope representation, e.g. advice-only or drafting of pleadings. But these cases will probably not do much to create social change, because social change cases require full representation over an extended period of time. So it is important for law faculties to be realistic and honest about their goals. This may require them to choose among possible objectives.

Contrary to conventional wisdom, the major obstacles to sustainability of clinical programs may not be a lack of funding. It is, of course, easier when one has funding, and many schools failed to pick up responsibility for funding clinics when outside funding dried up. But since clinics must, for the reasons discussed above, be formally approved and integrated into the law school curriculum, they have space and equipment.

The bigger challenge is maintaining the necessary “human capital.” In the European system of legal education, contrary to the U.S., clinical faculty are burdened by the pressure to achieve academic advancement in a short period of time – LL.M, Ph.D, all within 6 years. In addition, early in their careers, European law teachers have substantial departmental responsibilities. They carry significant substantive course teaching loads, administrative duties, and responsibilities for assisting and supporting senior colleagues. (In addition, these senior professors will influence the promotion prospects of their junior colleagues.) Finally, they usually do not receive any credit for teaching clinics. So, European law teachers who would otherwise like to teach clinics are often faced with the need to give up activities – such as clinical teaching – which are not important for academic advancement. That is probably one of the reasons why a number of clinics failed in Central and Eastern Europe.

VII. Conclusion

What does the future hold? What are the prospects for clinical legal education in Central and Eastern Europe? These are the questions to which, it seems, there are no exact answers. CLE, in the last 15 or 20 years spread across Central and Eastern Europe. It “flourishes” in some countries, less in some other. But the fact is that the concept of CLE is not unknown any more to European legal educators.

There are four possible scenarios for the future of CLE in Europe:

1. Clinics will continue to spread and will be fully accepted and accredited law school programs in all of Europe not just in CEE.
2. Most of the clinics will fail in time because it is not a traditional or typical teaching methodology in Europe.
3. Most clinics will fail because clinical education is not accepted as a teaching methodology on the EU level.
4. It is not predictable how clinical programs will continue in the future.

Which one of these scenarios we will witness in the future, in our opinion, depends a great deal on Western Europe, which to some extent has always influenced legislative and educational processes in CEE. This influence is even stronger now, when most of CEE countries are becoming part of the EU. What we can see at the moment is that CLE is being more accepted in Western Europe too. Proof for that is the recent initiative coming from Italy to establish the European Network for Clinical Legal Education (ENCLE)²⁶ which will serve as an umbrella organization and as a support to CLE throughout Europe. This might be the key that will widely open the door to European clinical education.

U.S. educators can also continue to contribute to these efforts, but in doing so they must recognize that Europe will develop its own CLE models, probably to some extent distinct from those in the U.S., and presumably more appropriate to the needs of European law faculties and civil societies. The best use of U.S. expertise may therefore be to facilitate the creation of opportunities – through conferences and websites – for European clinical teachers to exchange experiences, information, and ideas, and to engage in ongoing conversations with one another.

²⁶ About ENCLE see http://www.uc3m.es/portal/page/portal/instituto_derechos_humanos/sala_prensa/comunicados_de_prensa/encl.pdf; <http://www.iuctorino.it/content/european-network-clinical-legal-education>