AACTE
AMERICAN ASSOCIATION OF COLLEGES FOR TEACHER EDUCATION

A PIVOT TOWARD CLINICAL PRACTICE, IT'S LEXICON, AND THE RENEWAL OF THE PROFESSION OF TEACHING

THE AACTE CLINICAL PRACTICE COMMISSION

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PROLOGUE:

A PIVOT TOWARD CLINICAL PRACTICE, IT'S LEXICON AND THE RENEWAL OF THE PROFESSION OF TEACHING

> *"The education of teachers in the United States needs to be turned upside down. To prepare effective teachers for 21st century classrooms, teacher education must shift away from a norm which emphasizes academic preparation and course work loosely linked to school-based experiences. Rather, it must move to programs that are fully grounded in clinical practice and interwoven with academic content and professional courses." (NCATE, 2010).*

The NCATE Blue Ribbon Panel Report, *Transforming Teacher Education through Clinical Practice: A National Strategy to Prepare Effective Teachers*, a groundbreaking document released in 2010, called for clinical practice to reside at the center of all teacher preparation efforts. This clarion call identified 10 Design Principles to develop clinical practice programs and included recommendations for sweeping changes in the delivery, monitoring, evaluation, staffing, and oversight of teacher preparation. These design principles include the following:

- A focus on PK-12 student learning
- Dynamic integration of clinical preparation throughout every facet of teacher education
- Continuous evaluation of a teacher candidate's progress and of the elements of a preparation program
- Preparation of teachers who are simultaneously content experts and also innovators, collaborators, and problem solvers
- Candidate engagement in interactive professional learning communities
- Rigorous selection of clinical educators and coaches from both higher education and the PK-12 sector
- Designation of specific sites funded to support embedded clinical preparation
- Integration of technology to foster high-impact preparation
- Creation of powerful [research and development agendas] and systematic gathering and use of data to support continuous improvement in teacher preparation
- Establishment of strategic partnerships for powerful clinical preparation.

(NCATE, 2010)

Unfortunately, since the publication of the Blue Ribbon Panel report, reform and reinvention efforts have largely been scattered and at times haphazard attempts by programs and universities to grapple with what it means to immerse teacher preparation in clinical practice. A unified professional structure with a shared understanding of clinical practice has yet to develop in teacher preparation.

In 2015, AACTE formed the Clinical Practice Commission to further operationalize the findings of the report, so that the benefits would become readily identifiable in PK-12 and university-based teacher education contexts. The Commission is a call to action *by* the profession *for* the profession. As representatives of PK-20 contexts, we consider ourselves actors along the this schooling continuum, each with great value to add to the overall endeavor and each with the agency to impact the work. It is in this space that we expect to:

> rethink every aspect of the trajectory people follow to become accomplished teachers. [We are conscious of the fact that getting] that path right and making sure all teachers follow it asserts the body of knowledge and skills teachers need and leads to a level of consistent quality that is the hallmark of all true professions (Thorpe, 2014a, p.1).

As proposed by the AACTE Clinical Practice Commission, "clinical practice" is a model to prepare high quality teachers with and through a pedagogical skill set that provides articulated benefits for every participant, while fully embedded in the PK-12 classroom. By preparing teacher candidates through an interwoven structure of academic learning and the professional application of that knowledge—under the guidance of skilled school-based and university-based teacher educators—teacher preparation will experience the long-overdue pedagogical shift that so many have demanded (NCATE, 2010).

A Cacophony of Perspectives

Recent teacher education reform efforts have been characterized by their disparate nature and have been enacted far too slowly. The rate of the implementation of these initiatives has been muted by the sheer number of these restructuring efforts, the incorporation of an extraordinary range of suggestions, and the fact that they have been subject to shifting forms of accountability and political wrangling. Teacher education changes have also been impeded by the reality that they have been guided and sometimes misguided by well-intentioned funders and the recognition that our policies and practices must be responsive to our differing communities and contexts.

More recently, the rise of college and career readiness standards and more restrictive notions of "accountability" have led to a push for new teacher evaluation systems that more closely connect student outcomes to teacher effectiveness. *Race to the Top* requirements and a corporate education reform ideology have led to very narrow, drive-by, compliance-driven methods of teacher evaluation that have become normalized within schools and teacher preparation programs (Cochran-Smith & Villegas, 2014). The pedagogical principle of continuous improvement, with embedded formative assessments, has been diluted if not commandeered by these efforts. This is where the field uses its own science; Pedagogy, to inform the renewal of the profession of teaching by those who know its complexity best.

Unfortunately, the wide-ranging critiques, ever-shifting reform ideas, and high-stakes accountability efforts are contributing to increasingly *fragmented* rather than *focused* research agendas. The result is that we measure "quality" in a myopic manner. Annual Professional Performance Reviews (APPRs), brought on under NCLB legislation, and reinforced by Race to the Top competitive grants, operate in sharp contrast to the standards of quality defined by the profession itself.

In this context teachers are at once expected to be practitioners who are knowledgeable, decisive, reflective, and able to promote critical thinking and problem-solving in every child (Cochran-Smith, 2014; Zumwalt, 1997), and yet they are simultaneously called on to explicitly and positively impact our nation's economy by eliminating drop-out rates and developing a skilled workforce (NCTAF, 1996). As the demands upon *teachers* have evolved, so have the expectations of teacher *candidates*. There is a dynamic tension here, between high "quality" and the everyday demands of back-breaking accountability. This tension is best mediated by those professionals who understand it and live it—university-based and school-based teacher educators. While teacher preparation and accountability measures aim to ensure that novice teachers are learner ready when they first step into a classroom, these policies also reflect a linear view of teaching—suggesting an input/outcome orientation that dilutes the human equation at the core of every teaching act.

This complex interplay of factors has impeded the development of a shared understanding of clinical practice. Of course, teaching requires specialized knowledge and skills that are grounded in theory and practice and are developed over time. Yet, a shared understanding of what constitutes a high quality clinical teacher preparation program varies by institution and even program. Unlike other recognized professions—such as medicine, engineering, and nursing—teaching is eternally gripped by an evolution of our notions of quality that seems to begin anew with each school year and every Congressional session. The characteristics of our profession are therefore in continual process (Lortie, 1975).

This sets the stage for the following concept paper articulated as proclamations and their related tenets. The goals of the Clinical Practice Commission is to be bold in their

recommendations and forthright in their purpose. The Clinical Practice Commission had three primary charges for their work:

- Recommend a definition for Clinical Practice
- Recommend a lexicon for Clinical Practice
- Recommend pathways to operationalize Clinical Practice

Here are the results of our work.

OUR GUIDING PROCLAMATION

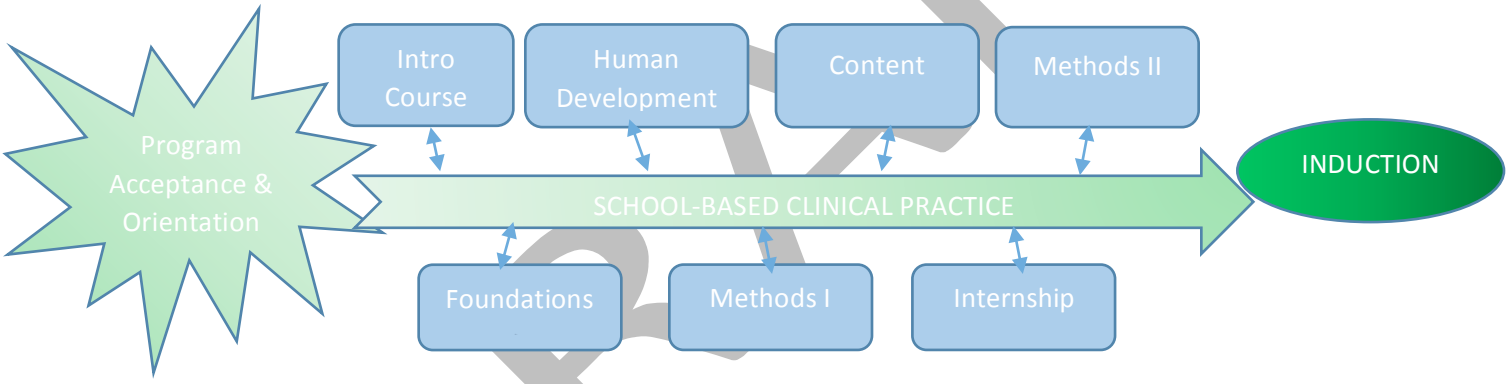
Clinical practice and partnership are central to high-quality teacher education is the assertion by which we begin this paper. Written by teacher educators and practitioners representing a collective of expertise in practice and scholarship across the PK-24 continuum, the assertions and proclamations contained herewith are intentionally bold and aspirational. We build upon a rich cadre of experiences and a dedication to the ongoing renewal of innovative educator preparation practice. As such, we do not endorse any one model of clinical practice or partnership, although we do acknowledge and identify Professional Development School (PDS) and teacher residency models as significant exemplars for practice because of the longevity and prevalence of these approaches as accepted frames for establishing and implementing highly-effective clinical preparation programs. These models are an important part of the history of clinical educator preparation, and should not limit the development of clinical partnership models that are designed to meet local needs and utilize locally available and appropriate resources.

Fundamentally, clinical practice (as described in this paper) is non-negotiable. Successful clinical practice programs and partnerships have been actualized since the NCATE Blue Ribbon Panel report, Transforming Teacher Education through Clinical Practice: A National Strategy to Prepare Effective Teachers was released in 2010, however, continued refinement and support for

the contexts and conditions necessary to bring clinical educator preparation to scale as common practice are needed and imperative to renewing and unifying the teaching profession. The aspirations evident in the policies, structures, rewards and forms of compensation that define and shape the structure of teacher education must be the most rigorous, ethical, and professional we can imagine. This paper, therefore, outlines proclamations and tenets considered essential to establishing and advancing clinical educator preparation partnership and practice that is both highly effective and responsive to the localized contexts in which it is implemented.

GUIDING CONCEPTUAL MODEL

The guiding conceptual model puts clinical practice at the center of high quality teacher preparation.



THE PLUMB-LINE PROCLAMATION

We assert that clinical practice is the plumb-line that runs through high quality teacher preparation

Tenet # 1*: Viewed thusly, clinical practice serves as the anchor or plumb-line through which all teacher preparation programming is conceptualized and designed. In a clinically-based program, where clinical practice is central, coursework is designed and sequenced to intentionally support candidates' developing knowledge and skill as evidenced through authentic practice in diverse settings and contexts. Thus, in a clinically-based program, coursework is designed to complement and align with field experiences that grow in complexity and sophistication over time.*

***Tenet # 2**: Clinical practice and research are intrinsically linked and together form the basis for the plumb-line that delineates high quality clinical educator preparation practice.*

***Tenet # 3**: Creating the conditions for clinically-based educator preparation means back-mapping from accomplished standards, both in articulating what accomplished practice is and how to measure it and then creating the systems that allow teacher candidates to develop over time and under the supervision of accomplished practitioners.*

***Tenet # 4**: In sum, it is precisely because the actual process of learning to teach requires sustained and ongoing opportunities to engage in authentic performance that clinical practice be seen as a valuable, necessary, and non-negotiable component of high quality teacher preparation.*

In recent decades, a consensus has grown among researchers and practitioners alike. Teaching is a complex practice, learned over time, through rigorous and deliberate study, combined with thoughtfully orchestrated opportunities to practice. Whereas traditional models of teacher preparation often provide teacher candidates with a series of distinct campus-based courses that culminate in a field-based student teaching semester, we assert in this brief the centrality of clinical practice to the entirety of a candidate's preparation to teach.

THE PEDAGOGY PROCLAMATION

We assert that as pedagogy is the science of teaching, the intentional integration of embedded pedagogical training into an educator preparation program is the cornerstone of effective clinical practice.

As the science of teaching, pedagogy guides the central practice of teachers and teacher educators. Often, the field has sub-optimized the value and worth of this anchor. The "cacophony of perspectives" have clouded the waters in which we negotiate and articulate the ever evolving needs of children in today's schools. We assert that pedagogy is the beacon on which we must depend to navigate these clouded seas. It is our theoretical underpinning, our foundation for asking questions, and the basis upon which we move forward.

***Tenet # 1:** The presence of strong, embedded pedagogical training is the hallmark of effective clinical educator preparation.*

Tenet # 2: *A program cannot be defined as demonstrating clinical practice without the presence of strong, embedded pedagogical training.*

Tenet # 3: *Pedagogy serves as a guidepost for shared professional standards of best practices in teaching that in turn guide the development of clinical practice models.*

THE SKILLS PROCLAMATION

We assert that clinical practice includes, supports, and compliment efforts to improve teacher education, such as through the use of high leverage practices and similar core strategies, as part of a commitment to continuous renewal.

Tenet #1: *University based teacher educators, School based teacher educators and Boundary spanning teacher educators cannot be beholden to existing assumptions about educator preparation or bounded by traditional practice.*

Tenet # 2: *Mechanisms for teacher preparation and professional teacher development need to be aligned, research-based, and professionally embedded.*

Clinical practice as defined by the CPC ensures intentional pedagogical experiences are provided in authentic educational settings. Thus, clinical practice should import a focus on high leverage practices at the core of teacher education while methodically training teachers to use these practices within clinical practice sites (Grossman, et al., 2009). High leverage practices are defined as "a set of practices that are fundamental to support PK-12 student learning, and that can be taught, learned, and implemented by those entering the profession" (Windschitl, et al., 2012, p. 880). McLeskey and Brownell (2015) assert the need for "identifying a set of high-leverage classroom practices that all teachers must learn" (p. 7).

These embedded experiences create an environment for simultaneous and continuous renewal that benefits all stakeholders; thus, shifting away from the compliance-driven educational culture provoked by NCLB legislation and reinforced by Race to the Top competitive grants. Pedagogy and the expertise of the education professional should be lauded as

a mechanism for the improvement of both clinical educator preparation programs and PK-12 settings. As Goodlad (2004) poignantly conveyed, "school renewal creates an environment—a whole culture—that routinely conducts diagnoses to determine what is going well and what is not" (pp. 156-157). Without embedded clinical practice with a focused on intentional pedagogical experiences in authentic educational settings, continuous renewal is not only unrealistic, but the ability to utilize high-leverage classroom practices is implausible.

VanMaren (1991) discusses the need for teachers to engage in "pedagogical thoughtfulness" or "mindfulness toward children" and to "consider how things are for the child" (p. 11), which provides a holistic view of the teaching and learning process. Skilled practitioners engage in continuous reflection that is centered on the pedagogical understanding of each child's needs, making instructional decisions based on successes and challenges encountered in their day to day work. Thus, clinical educator preparation must shift away from traditional practices in which teachers spend time outside clinical practice sites learning the methods of teaching and, at a later time, are guided through the praxis of teaching (application of those methods in practice, traditionally referred to as the student teaching experience). Only when pedagogy is deeply embedded within clinical practice sites can simultaneous and continuous renewal be attained and pedagogical mindfulness be achieved to facilitate PK-12 student learning.

Practicing *pedagogical mindfulness* provides renewed clarity of reflective practice, a cornerstone of educator preparation programs for decades. Loughran (2002) describes reflective practice as "a meaningful way of approaching learning about teaching so that a better understanding of teaching, and teaching about teaching, might develop" (p. 33). Like many professions, educators have engaged in reflection to better understand teaching, learning, students' needs, as well as social and contextual variables that impact their craft. Pedagogical

mindfulness refines reflective practice with an emphasis on being mindful during the pedagogical moment of teaching, acting (or not) in the moment, and reflecting on the pedagogical action (VanMaren 1991). It is the "in the moment" praxis and reflective practice that provides the most meaningful professional teacher development.

The Professional Development School Model focuses on the same type of mindful pedagogical practices within clinical teacher preparation, through the use of observation, coaching, co-teaching, dialogue, and reflection on teaching. As illustrated above, these research-based components best support teacher preparation and professional development within embedded clinical experiences. Through an active clinical practice process, mentor teachers work shoulder to shoulder with teachers in training, which results in a deeper understanding of teaching and learning for everyone involved in the clinical practice experience.

THE PARTNERSHIP PROCLAMATION

We assert that clinical partnerships are the foundation of highly-effective clinical practice.

Tenet # 1: *Clinical partnership, as distinct from clinical practice, is the vehicle through which the vision of renewing teacher preparation through clinical practice is realized.*

Tenet # 2: *Effective clinical partnerships are gateways to developing reflective practice centered around preparing highly effective educators while simultaneously renewing teaching and learning in PK-12 classrooms.*

Tenet # 3: *Effective clinical partnerships allow for mutually beneficial outcomes for all stakeholder partners alongside a shared focus on improving success outcomes for PK-12 students.*

Tenet # 4: *There is a strong research base to support the benefits of clinical practice partnerships for both schools and teacher preparation programs, resulting in benefits for the improved preparation of teacher candidates and success of PK-12 students.*

Teacher preparation implemented within a clinical partnership establishes a firm foundation of highly effective clinical practice. Implications of innovative, rigorous partnerships

are necessary for preparing high quality teacher candidates in an ever-changing educational society. An example of recognition for the significance placed upon clinical partnership can be found in the Council for the Accreditation of Educator Preparation's (CAEP) Standard for Accreditation. CAEP standard 2.0 calls for higher education providers to ensure that effective partnership and high quality clinical practice are central to preparation so that candidates develop the knowledge, skills, and dispositions necessary to demonstrate positive impact on all PK-12 learning. As demonstrated in this focus, and through the emphasis placed on clinical partnerships by exemplar teacher residency and PDS models, it is imperative that teacher preparation programs work to establish rich clinical experiences that weave together theory and application with the goal of preparing teachers for 21st century classrooms.

Clinical partnerships must be developed with an understanding that both bold and mutually beneficial outcomes are to be the end result. This is an essential consideration as potential community partners are being vetted. PK-12 partners need to possess a mission that aligns with that of the teacher preparation program and includes a commitment to the collective development of rich clinical practices. Both the schools and the university the partnership that must serve as the central driving force for the advancement of clinical teacher preparation and educational renewal.

Clinical partnerships must be committed to ongoing research efforts in order to inform practice, improve the quality of teacher preparation programs, and offer evidence of successful outcomes in the ever-changing educational climate. Although continued research is needed, the benefits of clinical partnerships are already supported with a strong research base. One such example includes an empirical study of the PDS model in preparing teacher candidates as best practice (Snow, 2015). This evidence-based claims of their report included:

1. PDS experiences encourage greater professional confidence in teaching candidates.
2. PDS experiences result in teaching candidates with more demonstrable teaching skills.
3. PDS experiences improve hose teachers' perceptions of themselves as professionals.
4. Candidates with PDS experience are better teachers.
5. PK-12 students demonstrate higher achievement through PDS experiences.

Additional claims that are still emerging and need more attention in the research are:

   a. PDS experiences encourage improved quality and/or frequency of formative assessment for teaching candidates.
   b. PDS experiences encourage improved quality of college/university courses.

Critical reflection is also important as it provides all stakeholders opportunities to think deeply, make connections, and challenge existing phenomenon in both the context of PK-12 classrooms and as it relates to curriculum and learning. Reflection on teaching is identified as one of six systematic and intentionally designed pedagogical routines used in clinical teacher preparation programs to support teacher candidate learning (Yendol-Hoppey & Franco, 2013). Reinforcing reflective practices is a core principle of the clinical partnership mission, in order to codify "a shared commitment to innovative and reflective practice by all participants" (NAPDS, 2008). To extend academic learning and allow for personal and societal learning to occur, reflection should be woven throughout clinical experiences and center around the preparation and practice of highly effective educators (Gibson et al., 2011).

THE INFRASTRUCTURE PROCLAMATION

We assert that a sustainable and shared infrastructure is required for a successful clinical partnership.

Tenet # 1: *Clear governance structures and sustainable funding models are key to establishing and maintaining successful clinical partnerships.*

Tenet # 2: *Individual teacher preparation programs and school districts have different needs and resources which must be at the focus of any and all governance structures and funding models so as to ensure the sustainability of the partnership.*

Tenet # 3: *The roles and responsibilities of both the school and university partners must be clear and defined.*

Successful clinical partnerships ensure a sustainable and shared infrastructure. Stakeholders must develop a deep understanding of the local contextual variables and consider how those factors might shape a partnership. This may include an exploration of the resources, opportunities and challenges of the community where district PK-12 school(s) are located and a consideration of how higher education institutions and schools could best work with the community. Understanding these contextual variables is facilitated through "a school-university culture committed to the preparation of future educators that embraces their active engagement in the school community" (NAPDS Policy Statement, 2008).

The context for university and school interactions occurs in a "third space", at the intersection of school and university where practitioner and academic knowledge merges (Gutierrez, 2008; Aeichner, 2010). Within this third space, it is imperative that clear governance structures are created for providing direction and nurturing equity and inclusivity between institutions of higher education and school districts. While clinical partners may be accustomed to diverse governance structures, reconciliation of any differing expectations will lead to structures suitable to mutual goals and outcomes. The roles and responsibilities of both school and university partners must be clearly defined to ensure success.

Teacher preparation programs and school districts also have diverse needs and access to different funding sources. As such, a commitment to identifying, establishing, and sustaining funding and resources must be a shared commitment made by both entities and a truly collaborative partnership fosters the context necessary to address this commitment. For example, in one clinical partnership, a university lobbyist advocated for ongoing funding in the state

legislative budget to provide ongoing financial resources for urban professional development schools. The university buys out one-half of four teacher salaries in the school district yearly, providing ongoing and shared financial support to four professional development schools.

THE DEVELOPMENTAL PROCLAMATION

We assert that clinical partnerships are facilitated and supported through an understanding of the continuum of development and growth that typifies successful, mutually-beneficial collaborations.

Tenet # 1: *There are stages to establishing and growing clinical partnerships that can be identified and shared to assist schools and universities embarking on these relationships.*

Tenet # 2: *The process of establishing, maintaining, and growing partnerships is non-linear and requires diligent commitment by all partners to working through the stages that typify a spiraling and evolving mutually beneficial relationship.*

Tenet # 3: *While there are common stages and actions identified with successful partnerships, each also possesses unique characteristics and requirements specific to its local context.*

Tenet # 4: *Ongoing assessment of partnership, including its effectiveness and impact, is necessary to ensure continued efficacy and sustainability.*

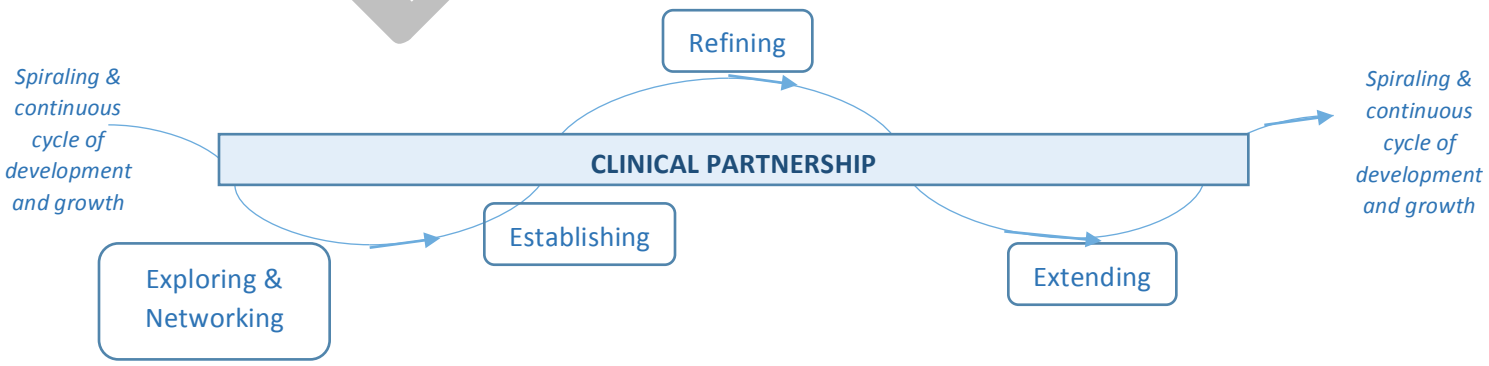
The development of clinical partnerships occurs in stages that can be identified and shared to assist schools and universities embarking on these relationships: Networking/Exploring, Establishing, Refining, and Extending. At first glance the stages appear linear, but they should be viewed instead as recursive and boundary-spanning throughout the lifetime of an evolving mutually-beneficial relationship.

In the *Networking/Exploring* and *Establishing* stages, all partners work together in a "third space" to identify their needs through close, open, and honest communication resulting in detailed implementation plans that identify key personnel, develop necessary policies and

procedures, and determine how resources will be shared. Once a clinical partnership is established and functioning, the partnership moves into the *Refining* and *Extending* phases during which all partners share responsibility for growing the partnership. Expectations for honest communication and meaningful collaboration are openly articulated, and data is collected and analyzed for the purpose of continuous improvement. As all partners contribute across the stages of a successful partnership the vocabulary shifts from "I" to "we."

Throughout all stages, all partners develop a deep understanding of the local contextual variables and how those variables shape the partnership. Ongoing assessment of the partnership's effectiveness and impact is also necessary to ensure continued efficacy and sustainability. As mentioned previously, for partnerships to thrive they must have clear governance structures and be able to rely on consistent locally-appropriate funding and policy support at all stages. However, should large-scale contextual changes occur, strong communication and collaboration are vital to the relationship building that will allow the partnership to persevere. Mature partnerships are not afraid of challenges and recognize the importance of celebrating accomplishments. Such partnerships are quick to address conflict and facilitate opportunities for problem solving so that solutions can be co-created.

Spiraling Continuum of Clinical Partnership Development and Growth:



Supporting Conditions for Partnership Development and Growth

1. **Clear governance structures & consistent and locally-appropriate funding and policy support.**
2. **Productive communication, purposeful collaboration & boundary-spanning relationships.**

THE EMPOWERMENT PROCLAMATION

As emerging professionals, teacher candidates are essential contributors and collaborators within clinical programs and partnerships.

Tenet* # *1: *The needs and responsibilities of teacher candidates should be factored into curriculum and infrastructure development when establishing or growing clinical educator preparation practice and partnerships.*

Tenet* # *2: *The progression of embedded teaching and learning preparation experiences, inherent to clinical practice, is essential to empowering teacher candidates to take active roles during their practicum experience as co-teachers in the classroom, as well as professionals within the school and larger community. These experiences promote profession-ready efficacy once candidates matriculate to the classroom.*

Teacher education curriculum is necessarily based upon the developmental, conceptual, and experiential needs of the teacher candidates and should be shaped by local conditions and opportunities inherent in the clinical education partnership sites, not the other way around. Historically, clinical educator programs have sought clinical placements which conformed to the curricular components of a particular course-a practice which often resulted in great frustration for everyone involved. Communication between the UBTE and the SBTE has too often been limited to hasty exchanges in the hallway and too often the SBTE has been asked to do most of the accommodating and flexing. A clinical partnership allows all participants to communicate clearly and to plan together regularly to ensure that both the PK-12 learners' and the teacher

candidates' needs are met. In addition, this approach allows customization of the learning experience for the teacher candidates who are just as deserving of culturally and developmentally responsive teaching and differentiation as are the PK-12 students.

This embedded teaching and learning practice allows the teacher candidate to be an active, rather than passive, participant in their own development and to experience first-hand the collaborative process in action between the UBTE and the SBTE. Just as all PK-12 students are not at the same developmental readiness level, each teacher candidate is uniquely poised to make specific contributions in the classroom and deserves thoughtful differentiation of the experiences and opportunities offered in each classroom. For example, teacher candidate "A" might bring rich experiences gained through four years of directing a summer program for children with special needs, whereas candidate "B" might have advanced knowledge of physics through an internship with NASA, but have little first-hand experience working directly with adolescent learners. Each candidate has much to contribute, but each needs different supports, approaches and opportunities for deepening their skills. This differentiation is only possible when the UBTE and the SBTE meet with the teacher candidate regularly to assess readiness and next steps within a committed and on-going partnership of trust and mutual respect for all participants.

THE MUTUAL BENEFIT PROCLAMATION

We assert that boundary-spanners, School-Based Teacher Educators (SBTE) and University-Based Teacher Educators (UBTE) play necessary, vital, and synergistic roles in clinical educator preparation.

Tenet # 1: *SBTEs and UBTEs must be highly qualified professionals, and in turn be openly valued for their expertise as demonstrated through acknowledgement and support for their roles in preparing future teachers.*

Tenet # 2: *SBTEs and UBTEs have a joint responsibility to foster teacher candidates in order to develop the dispositional characteristics necessary to be successful educators.*

Tenet # 3: *SBTEs and UBTEs need to re-conceptualize their roles as teacher educators, with SBTEs reflecting on how to effectively model best teaching practice and engage candidates as co-teachers in the classroom and UBTEs revisioning coursework to integrate candidate learning into school-based teaching experiences.*

Tenet # 4: *The clinical coaching of candidates is a vital and intensive endeavor that requires strategic and coordinated support. The evaluation of teacher candidates must be a shared responsibility between all teacher educators, involving regular and purposeful communication and meaningful, coordinated feedback about candidate progress.*

Tenet # 5: *Both SBTEs and UBTEs must participate in ongoing professional development about best practices in teacher education (i.e. high leverage teaching practices).*

Teacher education programs must embrace a clinical model of teacher preparation where the responsibility for teacher learning and development across the career is shared by university, school, and community stakeholders (e.g., AACTE, 2012; Blue Ribbon Panel, 2010; Bryk, Gomez, & Grunow, 2011; CAEP, 2016; Grossman, Hammerness & McDonald, 2009). To realize these mutual aims, UBTEs and SBTEs will need to sit across the table from one another and engage in open, honest, and occasionally difficult conversation. This work cannot happen if we remain in our separate silos; rather, universities and schools will need to proceed in a true spirit of collaboration (Koppich, Prince, Guthrie, & Schuermann, 2009). The establishment of these communication channels is especially true after implementation, as the task of refining and extending clinical partnerships demands the full commitment and active involvement of both teacher education programs and PK-12 school districts (Darling-Hammond, 2014).

The implementation of a clinical practice model requires a shift in how we define teacher educator roles and the consideration of third spaces, where practitioner and academic knowledge is integrated in a way that better supports teacher candidates' growth (Ipkeze et al., 2012; Williams, 2014; Zeichner, 2010). Such third spaces require teaching professionals to engage in

"boundary-spanning, positions in which their work as teacher educators takes place both on university campuses as well as in [PK-12] school classrooms" (Ikpeze et al., 2012, p. 276).

Working in these third spaces flattens the hierarchy between university and PK-12 instructors. It is our conviction that UBTEs and SBTEs must "have a foot in both worlds," as the old saying goes. Each must understand the opportunities and demands inherent in both the PK-12 setting as well as in the teacher education setting at the university. Gone are the days of the university "expert" appearing from time to time at the PK-12 school to impose the curricular need of a teacher education course upon school-based teachers with little regard for what is happening in the school. This approach includes creating hybrid roles for PK-12 teachers who work in the teacher preparation program.

The intent of a clinical practice model is to more intentionally connect coursework and fieldwork so that teacher candidates can experience, with support, the interplay between coursework and practice. This intentional connection encourages UBTEs to plan course tasks that have been co-created with SBTEs, and that are then completed during the clinical experience. When SBTEs and UBTEs plan together, co-teaching in both settings is a natural extension of this relationship and serves as a potent model of professional practice for teacher candidates. Teacher candidates thus become active participants alongside SBTEs and UBTEs as together they mutually support one another in applying pedagogical theories and high impact approaches in classrooms to address issues of PK-12 student engagement, teachers' classroom management skills, teachers' facilitation of discussions, differentiation of instruction, and authentic assessment of learning as everyone seeks to deepen their understandings and to hone their practice.

Clinical practice models begin with the learning needs of the PK-12 students. The experiences designed for teacher candidates pay specific attention to the needs of the instructional context. This approach requires working from the inside out and requires transforming the way both SBTEs and UBTEs plan curriculum and instruction. Clinical practice requires a shift beyond discussion of course content and sequence to re-conceptualizing curricula. Embedded in clinical practice is the assumption that teacher candidates will learn to teach within a complex and dynamic classroom environment by developing a reflective practice and the dispositions of a professional teacher. These clinical structures point to the importance of not only focusing on how long teacher candidates learn in the field, but also on what happens in the field and to the importance of building professional knowledge, performance, and practice within the PK-12 classroom and school.

SBTEs and UBTEs are experienced, properly credentialed, highly educated professionals who have a mutual respect and appreciation for each other's roles and responsibilities in preparing future educators. They work collegially to ensure PK-12 students are provided with high quality educational opportunities that are enhanced and strengthened by this SBTE and UBTE collaboration. While SBTEs and UBTEs share common goals and work closely, their roles and responsibilities are distinct, yet complementary. SBTEs assume coaching and partnership responsibilities in addition to their responsibilities for PK-12 student learning. Mentoring of teacher candidates is non-evaluative and includes such practices as focused observations, coaching, co-teaching, direct dialogue, inquiry, and reflections on teaching. UBTEs, who include clinical supervisors, clinical educators, clinical faculty member, and professional development school liaisons, are responsible for evaluation, coaching, methods instruction, and partnership support.

In clinical practice, the activities of the SBTEs and UBTEs are coherently integrated which requires conceptualizing the idea of what is considered pedagogy within institutions of higher education. Within teacher candidate preparation, UBTEs assume expanded and multiple responsibilities within, and often across, instructional activities in the PK-12 classroom. Through formal professional development offerings and informal opportunities in PK-12 classrooms, UBTEs can provide guidance to teacher candidates in classroom management, assessment and engaging lesson development throughout their clinical experiences (Henning, Gut, & Beam, 2015). Similarly, SBTEs can provide equally valuable insights to UBTEs and candidates by keeping everyone aware of the current PK-12 school culture and climate. This awareness then results in UBTEs better assisting candidates to better reflect on school based experiences and how those experiences link to educational theory embedded in the teacher education curriculum and in coursework.

Hollins (2011) identifies a set of "epistemic practices" consisting of focused inquiry, directed observation, and guided practice that can be used by SBTEs and UBTEs to develop teacher candidate professional knowledge. These practices engage teacher candidates, help them recognize the uncertainty associated with teaching and learning, and shape their professional habits and dispositions (Shulman, 2005a, 2005b). Shulman (2005a, 2005b), referring to these practices as the signature pedagogy of teacher education, describes the importance of researching these practices:

> Although signature pedagogy seems remarkably stable at any one point in time, they are always subject to change, as conditions in the practice of the profession itself and in the institutions that provide professional service or care undergo larger societal change. (p. 5)

In addition, Grossman, Compton, Igra, Ronfeldt, Shahan, and Williamson (2009) re-conceptualized teacher education into three pedagogical categories: representations, decompositions, and approximations of practice:

> *Representations of practice* comprise the different ways that practice is represented in professional education and what these various representations make visible to novices. *Decomposition of practice* involves breaking down practice into its constituent parts for the purposes of teaching and learning. *Approximations of practice* refer to opportunities to engage in practices that are more or less proximal to the practices of a profession. (pp. 2055-2056).

By intentionally following a communication plan throughout each semester between SBTEs and UBTEs who are teaching methods courses, course readings and assessments can be developed to align more closely with the current classroom curriculum and practice. This intentional planning also provides a vehicle to expand relationships, encourage reflection and provide increased opportunities to make connections between theory and classroom practice (Stanulis, 1995), while modeling effective pedagogical practice.

Collaboration between school communities and the university faculty also presents rich potential for joint professional development and grant collaboration that provides benefits to all parties. Also, having the opportunity to work closely with schools may lead to opportunities to investigate potential challenges within the schools and how the school and university communities might work together to address the identified needs (Shroyer et al., 2007) through mutually beneficial practices such as learning from teacher action research and joint scholarly inquiry.

THE COMMON LANGUAGE PROCLAMATION

We assert that coalescing the language of teacher preparation and teaching around a common lexicon will facilitate a shared understanding of and reference to the roles, responsibilities, and experiences essential to high-quality clinical educator preparation practice and partnership across local contexts and varying levels of stakeholder engagement.

Tenet # 1: *Implementing a common lexicon for clinical educator preparation facilitates consistency in the preparation, support, and induction of new and aspiring educators, as well as an understanding of the shared PK-24 responsibility for preparing future educators that is inherent and vital to effective clinical practice.*

Tenet # 2: *The application of a shared lexicon will provide a common language through which the expectations, roles, and responsibilities within clinical partnerships can be consistently articulated and understood.*

Tenet # 3: *Consistent use of a shared lexicon by all educators will serve as a linkage to establishing a more unified profession, as well as to provide a language that will enable external stakeholders to more consistently understand the aspirations and real-world practice of the teaching profession within the contexts of policy development, funding, and evaluation.*

Adoption of a common lexicon (vocabulary or language of a common body of knowledge) is imperative to unite and elevate the education profession. Too often, disparate and locally distinct terminology related to educator preparation makes it difficult for multiple stakeholder groups to communicate effectively about the profession. A common lexicon will help facilitate uniformity and stability in the way future educators are prepared, supported, and inducted into the profession by providing a common language in which communication can be clearly articulated and consistently understood.

Until a shared lexicon is adopted, the profession will remain disconnected making policy development, funding, and program evaluation autonomous processes instead of working toward a common goal that establishes a more unified profession. Once all stakeholders can consistently understand the language of the profession, they will better grasp and appreciate the attributes of clinical teacher preparation and clinical practice in which expectations, roles, and responsibilities within clinical partnerships are coherent and embraced by the field.

THE EXPERTISE PROCLAMATION

Tenet # 1: *While external stakeholders play a role in the development of policies and regulations that define guidelines, requirements, and processes for professional licensure, PK-24 educators must take the lead to guide, shape, and define the renewal of their profession.*

Tenet # 2: *Teacher educators, defined as all professional educators engaged in the preparation of future educators, must share responsibility for preparing and supporting aspiring and future educators to enter the profession.*

Tenet # 3: *With the knowledge that improving educator preparation is critical component in improving PK-12 student outcomes, external stakeholders and policymakers are vital and necessary allies in advancing clinical practice through the creation, support, and assurance of conditions that will secure sustainable resources and pathways for the long-term development of high-quality and effective clinical educator preparation programs and partnerships.*

Tenet #4: *The establishment of sustainable funding models are a pre-requisite for sustainable clinical practice. Therefore, as with other professions, support for efficacious models of embedded preparation, including paid residencies and internships, must be provided through dedicated and continuous streams of funding at the state and/or local level.*

Tenet # 5: *Local level policies in schools and universities must recognize and support the vital role that SBTEs and UBTEs play in preparing the next generation of educators through tenure, promotion and compensation policies.*

As mentioned prior, teaching requires expert knowledge and skills that are grounded in theory and practice and are developed over time. Yet, a shared understanding of what constitutes a high quality clinical teacher preparation program varies by institution and even program. Unlike other recognized professions—such as medicine, engineering, and nursing teaching is eternally gripped by an evolution of our notions of quality that seems to begin anew with each school year and every Congressional session. The characteristics of our profession are therefore in continual process[1]. However, educators are the experts in the field and are charged to utilize their expertise to create future teachers.

Yet, in both the current and historical climates, teachers have stepped aside deferring to outsiders to lead. This has led to the irrational assumption that teachers, in the traditional definition of the term, are meant to, and only have the skills to, instruct and guide those in PK-12. This is archaic and harmful to the profession. However, these thoughts are shared by those both outside and inside of the profession. Practitioners are the experts; they experience daily what traditional classrooms can't teach and need to step up and lead candidates to the skills that can't be acquired via a text book, but through real life classroom experiences mentored by a specialist. Clinically rich practice builds better candidates and the clinical model requires candidates to spend more time in the PK-12 schools. Thus, SBTEs and UBTEs need to be more invested in candidates than in traditional models and accept the notion that they are no longer "just teachers" but leaders to those new to the field.

However, SBTEs and UBTEs educators should not pursue this alone. It is our obligation to teach those who are not engaged in our profession and share with them what needs to be done as we seek a high-quality education for every child. Collaboration with key stakeholders is vital to develop a unified professional continuum that provides resources and embedded learning experiences to recruit, retain, and support the development and demonstration of professional competencies to cultivate leadership and mastery of practice for all teachers.

External stakeholders and vital to one of the key factors influencing the endurance and scalability of clinical educator preparation: the availability of resources from a dedicated and/or sustainable resources. In the medical profession, resources to support preparation of future physicians are provided through Federal and state funding models to teaching hospitals through Medicaid Supplemental Hospital Funding Programs that provide for financial exemptions, add-

on charges and buy-backs[2] to support teaching through the clinical medical model. As clinical preparation results in a system of education where all teachers are highly effective, the Bank Street College 2016 report *For the Public Good: Quality Preparation for Every Teacher* posits that residency models should be the norm in teacher preparation, and as such, should be supported as a public good[3]. As such, sustainable funding models are defined as:

- Non-political, with money streams that will withstand leadership changes;
- Public, not reliant on philanthropy or individual funding; and
- Adequate, providing supports for candidates to fully engage their learning experiences.

One would be hard-pressed to identify any occupation where prospective employees are expected to spend a minimum of a year offering their unpaid efforts as a condition for potential—not even guaranteed—employment. One would also find it nearly impossible to find a profession—one requiring an advanced degree and a specialized license—where apprentices are simultaneously required to pay for their training, again with the only benefit being the provision of the equivalent of an entry ticket into the field, rather than an offer of a contracted position. The very reasonable outcome of this model—what is in operation in the vast majority of teacher educational programs around the United States—is that, at best, entry to the teaching profession is delimited by one's ability and/or willingness to make these financial sacrifices. While ours is a capitalist nation, education is a human and humane endeavor; financial profits have no place in public schooling.

Even with sustainable funding, there are other barriers that must be addressed. Nationally teaching has been publically criticized alluding to the view that teaching is not seen as a valued profession in comparison to other fields. Unfortunately, the producers of teachers, institutions of higher education (IHE), may be aiding this negative and unprofessional perception without even realizing it. Often it is the faculty, staff and educators that participate in teacher education clinical practice that are not treated equally to their instructional peers. Professionalism of the field of teaching requires commitment from all constituents involved. This includes the producers and consumers of teachers; institutions of higher education and PK-12 schools. Higher education leaders need to take the first steps towards professionalizing teaching and changing both the campus and national cultures. IHE's need to recognize that teacher education as a unit for professional career preparation, and accordingly, will need to recognize the unique policy contexts necessary to advance efficacious clinical practice.

Tenure and promotion is an important aspect of a career in academia. The process aims to recognize and reward faculty and staff for their contributions to their field, students and institutions. Yet sometimes the important work of clinical faculty and staff is marginalized or even ignored in the tenure process making clinical work appear unattractive or not as valued as traditional academic activities. Institutions of higher education need to recognize that faculty and staff involved in clinical preparation play an extremely important role to the success of teacher candidates, PK-12 students and the entities they represent. As such, tenure and promotion policies need to reflect their value and not punish them for choosing a clinical career path. The difference between tenure and non-tenure track can be shockingly desperate. Job security, retirement, health insurance and other important factors can differ from a tenure and a NTT position depending on the institution. Clinical positons are valuable and classifying those as

NTT, devalues their importance. The CPC is using the term tenure in this case to not necessarily mean "tenure" in the traditional sense. However, the permanency of traditional tenure is what clinical faculty should be awarded. Whether it be called tenure or permanent appointment or something else, CFSE ought to have the same job security as other scholars in their institutions. Clinical preparation is an important factor in professionalizing the field of teacher education. However, if IHEs continue to devalue clinical faculty by making them unequal to their faculty partners via tenure and promotion policies, there is no reason why "outsiders" would value them either. Professionalization of the field begins with the treatment of those that work in training the field. Tenure and promotion policies should be conceptualized to recognize that the work of CFSE requires time and attention in areas that maybe be misaligned with current tenure and promotion categorical definitions. Or, their work may not fit traditional tenure and promotion categorical percentages. As such:

- Establishments of clinical partnerships, evaluation and assessment should be considered as an academic equal to empirical research
- Research and publication requirements must be valued to reflect the importance of planning and instruction in Clinical Practice settings.
- Course reductions need to be offered for clinical activities similar to grant releases
- Work as a clinical faculty should count towards service requirements (if necessary)
- Creation of a sufficient compensation program for SBTE's must be completed

The above list reflects the time, energy and intellectual requirements necessary for quality clinical education that results in highly trained candidates. Yet, current tenure, promotion and compensation programs treat SBTE and UBTE as though their work is not important. One example is compensation: although cooperating/supervising teacher (CST) stipends vary from state to state and institution to institution, it can be stated that in many cases, they are severely undercompensated. CSTs are highly educated experts in their fields, yet if you look at the hourly wage, some actually earn less than minimum wage for their activities. This is untenable in a

valued profession such as teaching. One can argue that they are already getting paid by their school district, but that is to teach their PK-12 students. Supporting a student teacher or intern requires extra work and time. In addition to insuring the PK-12 students are meeting their academic goals, the CST must also monitor the success of the teacher candidate. An additional work responsibility should be compensated as such and a few hundred dollars does not accurately reflect the importance of the job they are doing and the time spent on it. Additionally, it publically devalues the work of the CST and works against the idea of professionalization.

Moving forward, it must be reinforced to those both in and out of the field that teaching is a profession requiring specialized knowledge and preparation. PK-24 educators, as experts within the profession, must step forward and drive and inform the process and vision for renewing educator preparation. All stakeholders committed to improving educator preparation must be willing to invest in advancing and sustaining high-quality clinical practice as a center point for renewal resulting in PK-24 student success. The ripple effect of strong clinical practice can be felt for decades, if not centuries, as PK-24 students interact with the world beyond their classroom experiences.

CONCLUSION:

This paper began with the assertion that clinical practice and partnership are central to high-quality teacher education. Moving forward, the critical value of clinical practice as the plumb line for the ongoing renewal of effective educator preparation and practice is an obligation of all professional educators to explicate to all constituents. Teaching is a profession requiring specialized knowledge and preparation, as well as a means through which educators can continue

to develop as professionals and leaders to the benefit of PK-12 students, and aspiring and novice educators for whom they serve as mentors, models and guides.

PK-24 educators, as experts within the profession, must step forward and drive the process and vision for the ongoing renewal of educator preparation. All stakeholders committed to improving educator preparation must be willing to engage in advancing and sustaining high-quality clinical practice the critical pivot point for renewal resulting in PK-24 student success. The ripple effect of strong clinical practice will be influential for decades, if not centuries, as PK-24 students interact with the world beyond their classroom experiences.

It is the intention of the Clinical Practice Commission that the proclamations and tenets outlined in this paper be a vehicle for strengthening, propelling and establishing clinical practice as the means by which future educators are prepared and professional educators are empowered. This pivot will best serve the needs of PK-24 students, as well as the next and future generations of educators. Clinical practice has proven itself as an assured pathway to the preparation of high quality educators as well as a structure through which we strengthen and define the continuum of a unified profession. The mutually beneficial partnerships that define effective clinical practice are the driver and the vehicle through which the profession is advanced. It is through this inextricably interwoven process for assuring that pedagogy and practice are learned, refined and mastered (within a professionalized continuum and context) that our profession move forward. Educators are the experts of our theory and practice, and therefore must take the lead in assuring that clinical practice is at the forefront of the renewal of our profession. This action assure that the application of pedagogy and practice in PK-24 classrooms throughout the nation are led by educators who are fully prepared and empowered to work together in a synergistic and

continuously renewing infrastructure that advances their ability to meet and represent the needs of the students in their charge.

The proclamations and their tenets set the stage for the next iteration of action-based highly effective practice across the United States. The Clinical Practice Commission envisions that the proclamations contained within this paper will inspire the profession to draw upon core research and the advancements in clinical practice that have taken place since the release of the Blue Ribbon Panel report to advance clinical practice as the norm in educator preparation and the basis upon which to professionalize the teaching profession. We seek to affirm and codify these proclamations and to formulate the language of teacher preparation and teaching around a common lexicon. The amplification of clinical practice will empower educators to work side-by-side to reinvent the structure of educator preparation and engage in education renewal processes in schools and institutions. These processes will address the unique characteristics of local contexts while simultaneously committing to clinical practice as the common pivot point to achieving a unified, expert, and empowered profession that is highly regarded and is poised for the next generation of learners.

THE LEXICON OF PRACTICE
(a beginning)

Clinical Practice Commission/AACTE

Glossary

Term	Definition
Educator	An inclusive term that encompasses the fullest range of professionally prepared roles (e.g., teachers, administrators, counselors, university professors, clinical coaches) in education contexts (e.g. schools, colleges, universities)
Educator Preparation	The broad work of preparing new *Educators* to enter the various roles in education contexts. An *educator preparation* program is housed in an accredited institution, is intentional and purposeful, and takes place via *Clinical Practice* partnerships between the *Educator Preparation* institution and a school.
Teacher	Any individual, prepared via an accredited institution, who has day-to-day responsibilities to use pedagogy to facilitate student learning in a school.
Teacher Preparation	The broad work of preparing *Teacher Candidates* to enter the teaching profession. A teacher preparation program is housed in an accredited institution, is intentional and purposeful, is implemented in partnership with local education agencies, includes clinical practice, and leads to licensure.
Clinical Practice	*Teacher Candidates*' work in authentic educational settings and engagement in the pedagogical work of the profession of teaching, which is closely integrated with educator preparation coursework. "Clinical Practice" replaces the term fieldwork.
Clinical Practice Setting	A school that works closely and intentionally with an accredited *Teacher Preparation* program to provide *Clinical Practices* for *Teacher Candidates*.

Teacher Candidate	An individual formally admitted to an accredited *Teacher Preparation* program that leads to teacher licensure.
Clinical Internship	A specific type of *Clinical Practice*: the culminating clinical practice experience, which can be of varying duration but no less than one university semester. During the *Clinical Internship* teacher candidates assume full responsibility for the pedagogical work under the coaching of school- and university-based teacher educators. Clinical Internships require sustained partnerships between teacher preparation programs and local education agencies.
Mentor Teacher	A *Teacher*, identified as an exemplar and formally prepared as a clinical practitioner, who serves as the primary *School-Based Teacher Educator* for teacher candidates completing *Clinical Practices* or an *Internship*.
Boundary-Spanning Teacher Educators	Individuals (typically district or university personnel) working in hybrid roles across school and university contexts. These individuals serve *Teacher Candidates* at any point along a professional continuum and are active participants in teacher preparation.
School-Based Teacher Educator	Individuals involved in teacher preparation whose primary institutional home is a school. *School-Based Teacher Educators* are a specific type of *Boundary-Spanning Teacher Educators* who assume mentoring and partnership responsibilities that are in addition to their school responsibilities. This subsumes the terms university liaison, site facilitator, cooperating teacher, mentor teacher, collaborating teacher, school liaison.
University-Based Teacher Educators	Individuals involved in *Teacher Preparation* whose primary institutional home is a college or university. *University-Based Teacher Educators* are a specific type of *Boundary-Spanning Teacher Educator* who engage in evaluation, coaching, instruction, and partnership and assume expanded and multiple responsibilities within, and often across, each of these four domains. This subsumes previously used terms such as university supervisor, university liaison, clinical supervisors, and clinical faculty.
Clinical Coaching	*Clinical Coaching* represents the bridge between the work of *University-Based* and *School-Based Teacher Educators* engaged in *Teacher Preparation* and the practices in which these individuals engage. This term subsumes supervision and mentoring.

"School" assumes PK-12 settings as well as all local education agencies

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