Reality—Really?

A Response to McFaul and Cooper

LEE F. GOLDSBERRY

The conclusion drawn by McFaul and Cooper in the preceding article is best summarized in these two sentences:

> Attempting to change *individual* instructional approaches in a system that is unreceptive to collegial problem solving and teacher initiative may be futile. What is needed is an environment congruent with sustained professional development.

I am very dissapointed. Although the authors recognize the need to bolster research in clinical supervision and to document how such efforts are transformed in practice, they fail to do either. While I would have liked to have seen a detailed description of the design and results of an intervention based on the clinical supervision model, I learned instead that the host school displayed characteristics of a bureaucracy and that the authors question the compatibility of a bureaucracy with an intervention stressing complexity and adaptability.

Wouldn't it be interesting (not to mention pertinent) to know what the consequences of their intervention were? Elsewhere (McFaul and Cooper, 1983), these authors reported that participating teachers felt the observation cycles were valuable and described their feelings as positive. While the teachers' sentiments are not necessarily an accurate appraisal of the merit of the intervention, is there any reason to believe the authors' sentiments are superior? I, for one, would like to know what, if anything, the teachers changed in their teaching.

I am further dismayed that the authors fail to establish any relationship between what they characterize as a hostile environment and the conclusions they find disappointing. Instead, they list four disappointments about the way the teachers conducted their observation cycles and four organizational characteristics that seemingly contradict the "spirit" of clinical supervision—without discussing how any of these organizational characteristics influenced the disappointing conclusions about "peer clinical supervision."

Disappointment number one concerned preobservation conferences that were "done cursorily, if at all." How is the school milieu responsible for that? Isn't it more likely that the problem stemmed from an intervention design that called for full-time elementary teachers to participate in eight cycles of clinical supervision (four as "supervisor" and four as teacher with four different colleagues) in *four weeks*, and which provided no structured time for preobservation conferences. If so, is it possible that *their intervention*, and not clinical supervision, might be ill-designed for urban schools?

Disappointment number two is that the data collected by the teachers were often "insufficient . . . for drawing meaningful generalizations." "Meaningful" to whom? Even accepting the authors' appraisal of the teachers' data collection procedures, the question of how to attribute such behavior to the school climate is puzzling. Might an objective analyst suggest inadequate preparation of the teachers to function as clinical supervisors as another plausible explanation?

Inadequate preparation might also explain disappointment number three—"in-depth analyses occurred only in approximately 20 percent of the conferences. Given the press of time, the limited (11 meetings?) preparation, and the fact that each cycle was done with a different colleague, it's a pleasant surprise that "in-depth analysis" actually was done in 20 percent of the cases. Wouldn't it help us understand and assess the impact of the intervention if we had some idea of the teaching changes attempted—regardless of the investigators' judgments as to the depth of the analysis?

McFaul and Cooper also seem concerned that teachers did not question the accuracy of collected data. I fail to comprehend how a teacher's failure to challenge the *accuracy* of collected data suggests deficiency in the ability to analyze. Indeed, assuming collected data were low-inference quantifications, I wonder that anyone could expect them to be challenged. Seriously, how would that go? Would the observer say, "You asked 14 questions," and the teacher respond, "I did not"? Disputing the accuracy of observations seems somewhat lacking as an indicator of analytic ability—especially when the authors tell us that differing *interpretations* of these data were offered.

Again, I fail to see how any of these disappointments—which are the only indications the authors give us that the intervention was less than entirely successful—result from the milieu of the school. The authors' portrayal of the organizational environment may be quite accurate. Their assertion that incongruity between institutional systems such as personnel evaluation and clinical supervision can undermine productive change is sound. It surely can. But, *did it* in this case? I honestly don't know. It seems at least equally likely that *the design and delivery of this particular intervention contributed the telling blow to its success.*

I have yet another reservation about this offering. Even though I am a proponent of colleague consultation, I cannot agree with the authors that assumptions

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underlying the clinical supervision model are identical regardless of who does the supervision—supervisor or peer. Their attempt to generalize their conclusions from this specific intervention—using teachers as supervisors and providing no return observations by the same "supervisor"—is unwarranted, disclaimers and qualifiers notwithstanding.

It is obvious that McFaul and Cooper are disappointed with the fate of their intervention. Certainly, their observation that the climate of a school can influence events is neither disputable nor novel. Absolutely, we need to document the obstacles to implementing clinical supervision in the schools and record and publish adaptation processes and consequences. Assuredly, we must put such ideas as colleague consultation and clinical supervision to the test of fire by applying them and documenting their impact. But, sadly, the authors have not done this. What is *not* needed is another wailing that conditions in our schools, even in our urban schools, are so bad that they will overcome the best of our efforts. If "what is needed is an environment congruent with sustained professional development" before we can try to improve teaching, we will be banned from most of our schools, not only urban schools. "Sustained professional development" is simply not characteristic of most school environments. The challenge for school leaders and for educational researchers is to find and use tools that promote such professional growth and help overcome the bureaucratic influences that inhibit such development. Obviously, efforts to test these tools must be conscientiously coordinated with school leaders so that delivery can be compatible with the daily demands of the school. Whether or not "peer clinical supervision" can be such a tool remains to be seen. We need better tests of "reality"—really.□

No Wonder It Didn't Work!

A Response to McFaul and Cooper

ROBERT J. KRAJEWSKI

I challenge McFaul and Cooper's conclusions and suggest instead that their experiment failed because of poor design and implementation.

Any project, especially one as demanding in knowledge base, administrative support, and skills as is clinical peer supervision, must be introduced with proper timing to the proper audience. This project (1) appeared to ask the impossible of teachers, (2) afforded an unfair test of clinical supervision, (3) asked for too much in too short a time, and (4) thus assured a negative outcome. One of my colleagues, in commenting on this article, said, "It's an excellent essay to be read by persons contemplating a peer clinical supervision system—in terms of what *not* to do." Paradoxically, therein may lie the article's greatest value.

Without administrative and supervisory support, peer clinical supervision programs will have little or no chance to succeed. Thus training efforts must begin first with administrators—the superintendents, supervisors, and principals—and they must include both the concepts and the process of clinical supervision. In the beginning session of a recent clinical supervision training program, the most important concerns of trainees were:

1. Why should we be involved in clinical supervision?
2. How can we develop a positive attitude?
3. What risks must we take?
4. What skills do we need?
5. How can we find time to implement the program?

Such questions cannot be answered by emphasizing process only. Concepts must also be emphasized; the whys and hows must be integrated.

Seven concepts provide a firm foundation for clinical supervision programs.[1] Clinical supervision:

1. Is a deliberate intervention into the instructional process, requiring planning for what and when to observe, which type of analysis to use, and the roles each participant assumes. This behavior:
2. Creates productive tension for both teacher and supervisor. Lack of analysis skills, rapport, nurturance, observation, use of instruments, or time management produces unproductive tension. Reducing tension:
3. Requires supervisor knowledge and training.
4. Is both technology and use of technology. Its objectivity:
5. Is goal oriented and systematic, yet flexible, to better meet teacher needs and thus:
6. Requires mutual trust and the nurturing of rapport, a situation that:
7. Fosters role delineation.

Trainees must have a rationale for, information about, and necessary skills inherent in these concepts. Concept and process must co-exist for clinical supervision to be successful.

I urge readers not to become discouraged. When properly introduced and implemented, clinical supervision can be a powerful force in improving instruction. *Peer* clinical supervision, if built on an existing support system, can also be a powerful force in improving instruction. McFaul and Cooper's article presents an unfair test of peer clinical supervision in that it was improperly introduced to the wrong audience without a positive existing support system. It didn't have a chance.□

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[1] Robert Krajewski, "Clinical Supervision: A Conceptual Framework," *Journal of Research and Development in Education* 15 (1982): 38–43.

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