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.