Right Skilling and Organizational Change: Lessons from Doctors, Applied to Rabbis

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In 2010, a collection of prominent physicians and medical educators formed a Lancet Commission to assess the current state of training healthcare professionals. Recognizing the lapse in time since the last major assessment of medical education, the famed Flexner Report published 100 years earlier, the Commission began *Health Professionals for a New Century* with the following observation:

By the beginning of the 21st century, however, all is not well. … Professional education has not kept pace with [new] challenges, largely because of fragmented, outdated, and static curricula that produce ill-equipped graduates. The problems are systemic: mismatch of competencies to patient and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labor market; and weak leadership to improve health-system performance. Laudable efforts to address these deficiencies have mostly floundered, partly because of the so-called tribalism of the professions—i.e., the tendency of the various professions to act in isolation from or even in competition with each other…. What is clearly needed is a thorough and authoritative re-examination of health professional education, matching the ambitious work of a century ago.[[3]](#footnote-3)

As we reconsider the role and education of rabbis for the century ahead, even a brief glance of this report’s introduction, without any context, is striking. In spite of the obvious differences between physicians and rabbis, and in spite of similarly clear differences between delivering healthcare and building vibrant Jewish communities, similar forces have put pressure on traditional approaches in both arenas, and the shortcomings in training today’s healthcare workers are astonishingly parallel to the shortcomings of training today’s rabbis.

This chapter therefore piggybacks off the insightful and probing research into educating physicians, aiming at the very least to begin a conversation about what might be transferable to the future of the rabbinate and rabbinical education. We approach this topic as neither rabbis nor physicians but as congregational lay leaders who have recently participated in rabbinic search processes and as professionals whose careers have had us delve into matters of professional education, community organization, and institutions that either embrace or resist innovation.[[4]](#footnote-4) While we aim to bring both some personal experiences and professional expertise to our inquiry, we do our best to learn from those who have engaged in a thorough, in-depth inquiry into a similarly struggling profession. We begin by describing the problems that leaders in healthcare and medical education have diagnosed in their own profession and the reform recommendations they have prescribed. We next discuss how the challenges before the rabbinate and congregations closely mimic those challenges described in the health sector, and we close with lessons that, we hope, can meaningfully inform the development of a rabbinate for the 21st Century.

*The Challenge of Developing a 21st Century Healthcare Workforce*

The Lancet Commission begins with the observation that “the context, content, and conditions of the social effort to educate competent, caring, and committed health professionals are rapidly changing across time and space.” It chiefly observes that dramatic demographic and epidemiological transitions have produced more socially diverse patients than ever before, and at the same time, the rise of information technologies has empowered citizens to be active in how they consume health services and also proactive in their interactions with the healthcare system. Health educational institutions have had serious difficulty responding to these marked social and technological changes, promoting the Commission to give a frank and dire assessment:

Consequently, a slow-burning crisis is emerging in the mismatch of professional competencies to patient and population priorities because of fragmentary, outdated, and static curricula producing ill-equipped graduates from underfinanced institutions. In almost all countries, the education of health professionals has failed to overcome dysfunctional and inequitable health systems because of curricula rigidities, professional silos, static pedagogy (i.e. the science of teaching), insufficient adaptation to local contexts, and commercialism in the professions.

In short, a 21st Century healthcare professional must respond to a diverse, informed, and dynamic population, yet the institutions we rely upon to train these professionals—exhibiting rigidities that perhaps characterize most educational institutions and professions—are severely ill-suited to meet those challenges.

A pervasive theme throughout the Commission’s report, and a pervasive characterization of the current challenges, is one of *mismatches*: the Commission reports that there is “a maldistribution of professionals,” “glaring gaps and striking inequities” both within and between countries, and “skill-mix imbalances” in rich and poor countries alike. The problem is not necessarily one of constrained resources, but instead one of misdirecting resources. Health professionals are acquiring expensive skills that offer care to small populations and are not acquiring skills that produce significant benefits to large populations. They prepare for a career of giving directions to patients, rather than enabling patients to make good decisions on their own. And they are trained to work in expensive health systems, are unable to maneuver outside those costly frameworks, and are ill equipped to enable “patient management,” which has become the gold-standard for cost-effective care. As one knowledgeable commentator lamented, “our healthcare system delivers the wrong care by the wrong people in the wrong places.”

One growingly popular response to the pervasive problem of mismatch is to pursue “right skilling,” which simply means developing and employing professionals with the skills the health sector needs, rather than training providers with cost-ineffective skills with limited applications. For example, one report, produced from the Global Health Policy Summit that was organized by the World Economic Forum, identifies that the priority for rich and poor alike should be “to get the most out of human capital.” Entitled *A Neglected Resource: Transforming Healthcare Through Human Capital*,[[5]](#footnote-5)the report does not mince words in the inability to sustain the current trajectory, observing that “the global economic recession has created challenges in a way that has not been experienced since the Great Depression of the 1930s” and that there simply are not adequate financial resources to continue misusing human capital. Since so much of health expenditures are spent on human services, pursuing financially feasible health policies demands spending wisely on human capital.

The report suggests that a solution to the pervasive mismatch between professional competencies and patient needs is to rechannel how the health sector invests in human capital. The health sector currently overinvests in complex skills—skills that are both costly to develop and costly to utilize—and underinvests in more pervasively useful skills that have both widespread utility and are utilized more efficiently, and the authors therefore urge training professionals with less specialized, more widely applicable, and more rudimentary (and less costly) skills. Would a community be best served by investing a salary line in one doctor or in two nurse practitioners and a nurse? This approach to right-skilling, the report argues, not only would better equip professionals with the skills needed for 21st century medicine, and not only pursues a path of greater financial sustainability, but it also fits a model in which patients are encouraged to assert greater autonomy and control over their healthcare. In other words, pursuing a system of “patient management” is consistent with “right-skilling” and employing human capital most effectively and most efficiently. This collective approach is characterized in the following schema:



*Transforming Healthcare Through Human Capital* warns, however, that advancing this model of professional training and education will be difficult and disruptive: “In order to change the trajectories of health systems around the world, strong leadership and disruptive thinking will be required.” It isn’t likely that doctors will appreciate changes that make the system less dependent on doctors or that provides fewer jobs for doctors. Nonetheless, the authors observe that many leaders in medicine have already begun implementing this model:

What is clear is that some individuals and organisations – imbued with an entrepreneurial spirit and a willingness to think creatively – have seized the opportunity. Unbounded by orthodoxy, they have found new ways to reach more patients, at lower cost, while also maintaining or raising quality and improving work attractiveness and professional motivation. They are proven examples that excellence in quality, efficiency and productivity is possible. These organisations succeed despite legacy health systems, not because of them; they stand out as isolated beacons within established systems.

The Lancet Commission put the urgency more starkly, concluding that “complacency will only perpetuate the ineffective application of 20th century educational strategies that are unfit to tackle 21st century challenges.”

In sum, the need to reform the education and training of healthcare professionals is dire, but the path ahead is daunting. Professional skills must better fit the needs of the population, with an emphasis on instilling skills that are have greater applicability, are less costly to acquire, and follow a strategy of patient empowerment and self-management. The authors recognize that pursuing such a strategy requires major adjustments to well-established organizations, routines, and professional principles, but they urge the disruptive thinking and vigilant leadership that would enable the necessary reforms.

*The Challenge of Developing a 21st Century Rabbinate*

Technological, demographic, and social changes have also altered the terrain for today’s rabbis. Much like their physician counterparts, 21st century rabbis engage with a community that is more diverse, more independent, and more mobile than in previous generations.

At the same time, many Jews who are synagogue members have in mind an idealized version of a rabbi, the image of which was developed in a very different time. This rabbi has known the family for decades, presided over the kids’ bar and bat mitzvahs, is certain to accompany them under the chuppah, and perhaps will even console the kids—still living in the same community—when their parents pass away. This vision of the family rabbi is not unlike the idealized vision of the housecall-making family doctor of yesteryear. Yet many of the same powerful economic, social, and technological forces that have made the family doctor a thing of the past have also made the family rabbi an anachronism. These forces, which we now begin to explore, demand a new image of the rabbi’s professional role and open the door to considering new professional roles that might provide services that used to be in the sole purview of rabbis.

*Religiosity*. It seems that American Jews currently prefer expressions of their Jewishness that meaningfully differ from previous generations’ expressions. The recent Pew Study of American Jews indicates that a large and growing percentage of American Jews identify as Jewish by culture or ethnicity, but not by religion. Yet the American rabbi’s traditional role has been to offer spiritual, emotional, and educational leadership within a religious context, and synagogues—the primary employer of rabbis—continue primarily to be (and to be perceived as) places of religious worship. Twenty-first century rabbis, other than those that serve highly religious and insular communities, will have to generate a broad appeal and offer services that stretch far beyond religious contexts.

*Education*. In 21st century America, Jews have attained levels of secular education unimaginable to their ancestors and substantially greater than those of their grandparents and great-grandparents. With greater secular education—and perhaps with the accompanying inculcation of liberal democratic sensibilities—comes greater emphasis on individualism and personal autonomy, an appetite for explanations and justifications for rules and conduct, and a general resistance to presumed authority. And yet the American rabbinate was born at a time when secular education was less widespread among congregants, which in part meant a different rabbi-congregant relationship. The 21st century rabbi will need to adjust to the both the blessings and challenges of a highly literate, critically thinking, and intellectually demanding Jewish community.

In some respects, education has had predictable consequences. Just as it is the norm today for doctors to have highly educated patients, including those who (perhaps after having already done some internet research) have developed views of what amounts to proper treatment, it is similarly the norm for rabbis to have individually-oriented and opinionated congregants. Just as physicians’ instructions are less frequently accepted blindly and more frequently accepted only after thorough justifications, rabbis also are no longer figures of authority who informed congregants what the rules were and instructed congregants what to do.

Rabbinic reasoning has always welcomed debate and disagreement, and in many respects a return by rabbis to their ancient rabbinic roots will be well suited for dialogue and deliberation rather than mere instructions. But some other features of the rabbinic role will likely adjust less gracefully. One might be the matter of pervasive use by rabbis of their honorific titles, as opposed to their names, a practice that judges, physicians, and some other status professions still cling to, but which serves to distance rabbis from their congregants. Another flows from the fact that the rabbi’s role has often relied on having unusual access to certain materials or information—congregants, for example, were not well-versed in Jewish law or ancient Jewish transcripts—a kind of “secret knowledge” that was the hallmark of many ancient professions and guilds. But with translations and other materials available on the Internet, rabbis no longer have the informational advantages that they once did.

Rabbis, like physicians, need to adjust to this democratization of information. In the extreme, both physicians and rabbis have been informational intermediaries whose role is being partially displaced by sites like myjewishlearning.com and WebMD. (In truth, the amount of Jewish material available on the Internet is staggering, yet it was not long ago that a person had a only two routes to obtaining answers to substantive Jewish questions: spending time in a high-quality library or asking a rabbi.) As technology develops further, we can expect the further disintermediation of professional knowledge. Physicians have made meaningful beginnings to accommodating patients who have acquired significant medical information on their own, and part of that transition has had physicians become co-discoverers more than repositories of information, and facilitators and curators of knowledge rather than presumed experts. To be sure, there are many congregants who will continue to expect rabbis to have informational expertise and moral authority, and perhaps an additional challenge for the 21st century rabbi is to navigate multiple generations with different resources and demands. But there is little question that the degree and the nature of the education now enjoyed by American Jews, and their easy direct access to outstanding Jewish information, are presenting difficult challenges to the traditional paradigm.

*Mobility*. Twenty-first Century Americans—especially young ones—are substantially more mobile than they were in the past. The ideal of the American congregation is that of a stable community that stays connected to and invested in a single synagogue for many decades and perhaps generations, full of families who can be expected to be part of the community through multiple life-cycle events and throughout the childhoods of their children. But the 21st century American Jewish community is highly mobile, easily moving to different regions and just as easily switching synagogues.

Mobility brings obvious challenges for any community institution that relies on local financial support. Mobility likely makes individuals more price sensitive and less committed, over the long-run, to institutions that require legacy investments. Mobility also might undermine the strength of traditional rabbi-congregant relationships, which relied at least in part on deep understandings of family and community circumstances and a certainty of a long-term relationship ahead. It is hard to sustain these traditional relationships where “rabbi shopping” is common. Both the 21st century rabbi and the 21st century congregant must adapt to the reality that developing traditional rabbi-congregant relationships will be challenged by generational mobility.

*The Digital Age*. Though the “digital age” certainly has contributed to the widespread democratization of knowledge and to the population mobility, each of which are discussed above, it also has had a meaningful impact on our social and community structures that traditional Jewish institutions have not yet fully realized. We communicate differently, relying less on sermons or mass gatherings. We develop social relationships differently, relying less on fraternal organizations, community centers, youth groups, and the like. And we also synthesize information differently, glued to smartphones and tweets.

Much ink has been spilled on how the digital age has forced changes upon education, politics, and the media, and Jewish leaders have similarly been probing what the digital age has meant for the Jewish community. Rather than repeating that discourse, much of it extremely thoughtful, we merely observe that it is a technology that can potentially blindside traditional community structures, roles, and relationships.

*Dwindling Resources*. Although economic downturns are by no means uniquely 21st century phenomena, the Great Recession was by far the worst economic downturn faced by the Jewish community since the bulk of today’s communal infrastructure was built in the post-War years. Jewish institutions, at least for the first part of the 21st century, will confront severely limited financial resources in comparison with what they had before. Jewish institutions are facing a “double whammy” in that Jews have less interest in traditional Jewish institutions and also less financial means. The foreseeable future will thus continue to exhibit a declining desire of American Jews to pay—through membership dues, tuition, and charitable giving—what Jewish institutions have historically relied upon to function. Like healthcare professionals, Jewish leaders are confronted with new demands while also having to overcome the consequences of the Great Recession.

*Towards the 21st Century Rabbi*

Some American professional education programs in recent decades have, indeed, markedly changed the nature of their curricula because of rapid developments that often made the learning they offered obsolete before students graduated. Moreover, some of these (unfortunately isolated) changes have occurred in medicine. The Harvard Medical School engineered a dramatic change to its curriculum in 1985, underwent another major change in 2006, and is scheduled for yet another one in 2015. Harvard Business School also overhauled its curriculum in 2011, shifting from a case-study approach to one that emphasizes ethics and teamwork. Other areas of higher education are embarking on potentially dramatic strategic changes, in part necessitated by the challenge of on-line education, and the pace of curricular change in medical education appears to be accelerating as well. Thus, even within well-established professions, and even at age-old institutions, curricular change is possible when the demands for the profession similarly change.

Following the parallel lessons from medicine, we offer two primary recommendations. The first is to embrace the health sector’s pursuit of “right skilling.” Given the costliness, in both dollars and time, of training rabbis, we need to scrutinize critically the roles for which rabbis are truly necessary. Much like talented and appropriately expensive brain surgeons, rabbis should be used when their expertise is needed and when there are no substitutes. Otherwise, Jewish professionals with less elaborate and expensive training should have expanded roles in Jewish organizations. Professionals with master’s degrees in Jewish education could play greater roles in fulfilling educational missions traditionally assumed by rabbis, social workers with a year of enhanced Jewish study could play larger roles in pastoral counselling, and community organizers can assume leadership of Jewish community organizations. Even rabbis in more traditional roles need not in many cases require the extensive traditional training they now receive. For example, because information has become so much more widely available, including phenomenal audio and video lectures, courses, and books on the Internet, rabbis in some communities might serve them better as curators of the Jewish knowledge and experiences that are widely available, rather than owning expertise in many fields. Congregants often need only an informed purchaser to help them navigate the instructional materials available online, rather than needing an actual instructor. Thus, rather than learning to be experts or even teachers themselves, rabbis might be trained to serve as “concierges” for their congregants. (The Harvard Medical School pursued a similar strategy when it changed its curriculum in 1985, developing a “New Pathway” in light of the accelerating pace of medical discoveries, which aimed to adjust to the constantly changing status of medical knowledge; it became was less important for medical students to learn information than to learn how to think, how to learn continually, and how to avoid becoming committed to an inadequate cognitive model of disease that was likely to change soon anyway.) These concierges would not need five or six years of advanced study, but rather two or three years focused on the specific roles that they would play.

Jewish educational institutions should therefore invest in developing less costly and extensive training programs, and Jewish organizations should seek to employ these right-skilled professionals in roles that traditionally have been occupied by rabbis. Many synagogues (especially small congregations) might benefit more from a rabbi with skills that are tailored to the community’s immediate needs, perhaps in leading prayer and offering rudimentary adult education, rather than one that has extensive graduate-level training—a rabbi more akin to a nurse practitioner than the brain surgeon.

Our second recommendation, related to the first, is to encourage rabbis to reorganize themselves to accommodate for the both the need for specialization and the economic necessity for right-skilling. One effective model pursued by physicians, as medical practice became more complex, was the multi-specialty physician practice, in which no one physician was individually expected to master all the fields necessary to serve patients. Rabbis too might find it infeasible to fulfill all the elements of the traditional relationship with the modern Jewish community and similarly might find attractive the many efficiencies that compelled physicians to specialize individually while offering a full range of services as a group.

Pursuing a group practice model might indeed force a rethinking of the traditional rabbi-congregational relationship. Large congregations might be able to afford a large staff that captures all the necessary specialization, thus requiring little change, but a group practice approach would have a collection of rabbis serving a number of congregations. This approach might reflect the reality that it is increasingly difficult to find 300 families with sufficiently common needs and demands to sustain a mid-sized one-denomination synagogue. A rabbinic practice group would allow rabbis with different specialties to serve a number of congregations, and the model would allow multi-denominational congregations to exist without having to fight about what kind of rabbi to hire. The synagogues themselves would not have rabbis on their staffs, but rather their staffs would be made up of the “nurse practitioners” described above, and they would contract with a rabbinic practice group for a bungle of rabbinic services. The group’s brilliant sermonizer might come to a given synagogue once a month, while the moving-life-cycle-event specialist can be on hand for every wedding and bar and bat mitzvah at multiple smaller synagogues, as long as the schedules are coordinated, and can be on call for circumcisions and funerals. The great teacher can teach once a week at four or five different synagogues. Four (or more) synagogues could pay full-time salaries to a four-person rabbinic practice group and get outstanding rabbinical services in four different areas, rather than having to choose a rabbi who may be great at one thing but only mediocre at the other three.

If rabbis become specialized, then training of rabbis should also become more specialized. Rabbinic education could foster different specialties—pastoral care, education, prayer leadership, and public sermonizing—while also preserving the opportunity for some rabbis to remain generalists. Presumably, some rabbis will find themselves in traditional rabbinic positions in relatively large denomination-based synagogues that are able to survive as such, but many others would add play targeted roles and would require less expansive training. This would also mean that congregations would not be burdened by salary expectations that are appropriate for professionals expected to play leadership roles on multiple fronts.

A move towards reasonable specialization, with the efficiencies of collaboration, would offer some immediate rewards. It would open up advanced Jewish education, offering less expensive, less specialized degrees and training a greater number of Jewish professionals with the skills that Jewish communities severely need. It would offer more affordable professionals and enable struggling Jewish organizations and congregations to benefit meaningfully from long-needed efficiencies. And it might also offer rabbis more professional satisfaction, allowing them to specialize in accordance to their skills and passions while also alleviating the pressures of having to serve a community alone.

There are, to be sure, drawbacks as well. Something meaningful is lost when a rabbi is not squarely and exclusively associated with a congregation, and there might be a feeling of inadequacy when a congregation is served by a professional with more limited training than current rabbinic training. But, by the same token, congregations might find that a new approach, in which they are served by devoted right-skilled specialist professionals, is actually better. In any event, it is not helpful to pontificate only on the ideal rabbi, nor is it our agenda to praise or critique this new reality. Unless the traditional models somehow become both financially sustainable and adequate for modern demands, the training of rabbis must either prepare rabbis to confront and contribute to the new realities of Jewish life in America, or it ought to be training far fewer rabbis, as the numbers of jobs available for the old kind of rabbi are declining rapidly and will continue to do so.

*Conclusion*

Any professional education program must train professionals for the profession as it will be over the next forty years, not for the profession as it was in the last forty. Rabbinical training is no different. In times of stability, this is relatively easy to do, bringing to mind a recent New Yorker cartoon in which a cavemen tells his son, “When I was your age, things were exactly the way they are now.”



But in times of rapid Jewish change, such as our time, it is entirely unclear what the role of a rabbi will be (or ought to be) in four years, much less forty. As such, we need to educate rabbis to expect and embrace change, just as the medical profession is learning that doctors must be trained to do. Perhaps we need fewer rabbis, and—following the advice that Jethro gave to Moses in the Book of Exodus—rabbis need to see themselves as part of a system of professionals that works together to give each and every member of the community what he or she needs to move forward. We also are a “desert generation,” living in a time of wandering, and we need to be training rabbis accordingly.

1. † Bartlett Professor of Law and Business Administration, Duke University. [↑](#footnote-ref-1)
2. ‡ Founder and President, Institute for the Next Jewish Future, and Director, jU Chicago. [↑](#footnote-ref-2)
3. Frenk J, et al., Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World, *The Lancet* (December 2010). [↑](#footnote-ref-3)
4. As it turns out, both of us happen to be lawyers, though we readily concede that the common lessons drawn here could readily apply to our own profession [↑](#footnote-ref-4)
5. Victor J. Dzau, et al., A Neglected Resource: Transforming Healthcare Through Human Captial, Report of the Innovative Delivery Models Working Group 2012, World Economic Forum. [↑](#footnote-ref-5)