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Niederhuber Favors Hands-On Management, Revives Old NCI Organizational Structure

By Kirsten Boyd Goldberg and Paul Goldberg

In a one-hour interview with the editors of The Cancer Letter, NCI Director John Niederhuber described his strategy for managing the institute at a time of shrinking budgets.

The Senior Management Team, a layer of deputies installed by his predecessor Andrew von Eschenbach, would be abandoned in favor of "the older model of the institute in which the division heads... interact directly with me," Niederhuber said.

He described himself as a manager who gets into detail. He said he doesn't delegate scientific strategy, an area which has been the domain of Anna Barker, von Eschenbach's most controversial deputy, who championed large high-tech programs.

"Dr. Barker is very, very much a scientific colleague and a big help in managing some of our initiatives in nanotechnology and things like that, but I'm very much involved in that," Niederhuber said. "I don't know that I want to say that her function has changed, as much as maybe she has a different relationship with me than perhaps she did with Andy."

Niederhuber said he regards von Eschenbach's goal to "eliminate the suffering and death due to cancer by 2015" as a symbolic, rather than literal, target.

His decision to fund a $9-million pilot program, the NCI Community Cancer Centers, through a subcontract was a matter of expediency, not an effort to avoid rigorous peer review, Niederhuber said. He would have no "hesitancy" to submit the project to review by the Board of Scientific Advisors, he said.

In the interview, Niederhuber provided a detailed account of what went wrong with his two previous administrative jobs, as chairman of surgery at Stanford University, and director of the University of Wisconsin Comprehensive Cancer Center.

"I am a person that, if there is an elephant with a pink foot in the room, I'm likely to tell you, 'There's an elephant with a pink foot in the room, and have you really thought this through?'" he said.

Following is the text of the interview.

THE CANCER LETTER: Do you have a prospective plan for your directorship of NCI? What will this era be known for?

JOHN NIEDERHUBER: Hopefully, it won't be known as the Disaster Era of the Budget. It is a time, unfortunately, when we are going to have to work hard at managing the resources that we've been allocated. A big part of my responsibility is going to be focused on the budget and on communicating

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NCI Making "Hard Decisions" To Phase Out Programs

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the processes that we are using and the advice that we are getting, so that there is an element of transparency for the community at large, who are full of anxiety—as they should be—about the budget that we have and the resources that are available to support extramural research, especially the R01 grants and Program Project grants that all of us who have been members of academic faculty are so dependent on. That's certainly going to be a big responsibility.

But that doesn't mean that aren't lots of ideas and vision for NCI for our cancer agenda. In conjunction with that vision and with the budget pressures, it falls on the leadership of NCI to find ways to leverage additional resources. I plan to work very hard in that direction as well, to try to bring other resources to bear.

CL: Is the elimination of suffering and death due to cancer by 2015 still the NCI goal?

JN: Dr. von Eschenbach, I think, was very visionary and very bold, and believed strongly that the cancer community needed a strong goal to work toward. He set that goal for all of us.

I kind of think of that along the lines of my work over the years in terms of writing my research grants, for example. As all of us have done in the research community, we write our grants, we have a goal that we articulate in our grant. We have some strategic aims that we also describe of how we are going to achieve that goal. If we are experienced in grant-writing, we include as part of the grant a table that very clearly describes what we're going to accomplish in year 1, year 2, year 3, year 4, towards that goal.

So, all of us are used to setting goals. All of us recognize the importance of setting goals in order to try to keep focused and moving in the right direction, and moving as rapidly in that direction as we can.

Whether we, as a cancer community, reach a point in which we are pleased with our accomplishments and feel we are getting towards that goal of eliminating the suffering and death due to cancer by 2012, 2015, by 2020—I honestly don't think that any of us really know. But the important point is that we have a goal, that we are working towards that goal, and that the NCI is just as committed as ever to working as rapidly as we can, focusing our strategic planning on achieving that goal, working as rapidly as we can to get to that goal.

CL: It seemed that Dr. von Eschenbach meant this goal to be taken literally, and he made that point over and over again. I'm not hearing you taking this literally.

JN: I've given you my best explanation.

CL: At what point do you pull "NCI's 2015 Goal" off the website if it's not being taken literally?

JN: I think I've said what I want to say about this.

CL: How would you describe your strengths and weaknesses as an administrator? What do you bring to this job?

JN: I've been in the business a long, long time. My whole career has been dedicated to both laboratory research and to patient care—and to teaching and mentoring people at all levels. I'm very proud of my very first Ph.D. student, who was the president of the American Association of Immunologists this past year. I've trained a number of people in surgery.

I've sat on a lot of beds, held a lot of hands, shed a lot of tears with people who have suffered from this disease. I've had some success stories and value those Christmas cards tremendously when they come each year, but also had a lot of people who didn't survive this disease.

I bring a lot of experience at a variety of different levels in terms of the patient with cancer, of the research questions around that disease. I've been involved in administrative work, sometimes more than I wanted to be. I served a period of time at University of Michigan as the associate dean for research. I was asked by the vice president of academic affairs to fill in as the senior associate dean along with Peter Ward. Peter was the chair

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of pathology in those days, back in the early 1980s.

I remember Peter showing up at my home one night, knocking on the door, saying, "I've been asked to be the interim dean at Michigan. I told them I wouldn't do that unless you would join me." I spent three years or so literally leading the medical school along with Peter, although an awful lot of it fell on my shoulders.

I probably could have been the dean of the University of Michigan if I wanted to, but I told them that I didn't want to be the dean at that time. I was only in my mid-40s, I didn't want to be a dean. I wanted to continue my laboratory work and surgery. I certainly had a lot of experience those few years at a big medical school. At that time, we had significant financial problems. We were starting a huge hospital replacement project, building a research laboratory building. As a result of that, Al Shapiro told me that if I stay an extra year to help the new people get on board, I could do anything I wanted to.

That led me to go down to Hopkins as a visiting professor. I went to Tom Kelly's department in molecular biology and genetics, and was initially only going to be there for about six months, but they used to call me to come over to the dean's office to talk about different issues, and then they said I couldn't stay only six months. I was strictly in the lab—I had taken my tie off and had gone back to the bench and was doing my own research there. They wanted me to stay longer, and I said, "Well, I have to eat." They were sending a check to an account number at the University of Michigan so Michigan would continue to pay my salary. What they really wanted me to do was to stay at Hopkins, so I stayed there and enjoyed that very much.

Primarily, my office and laboratory was in the cancer center. I had another office in the surgery department, but served on the Executive Committee of the cancer center. I was very much involved with Al LoBuglio in developing the plans for the cancer center at the University of Michigan, and I remember having to go back to Michigan to present before the Board of Regents of the university this cancer center plan, so in many ways, I had my hands in starting the cancer center at University of Michigan.

CL: It's a matter of public record that you left your two most recent jobs under some pressure. What have you learned from those experiences?

JN: Maybe I learned that I should be more careful in which jobs I choose to take.

The Stanford job was a very interesting one. I don't know that I would, even with the experience I had, say that it was a bad decision to do that job. I think everybody who knows David Korn has great admiration for David Korn, and he's an outstanding experimental pathologist and a great academic leader in many ways. David was the dean at Stanford at the time Don Kennedy was the president, who had been at FDA before and had an interest in biology and an interest in the medical center. I don't know how many times I turned that job down every time David would offer it to me.

Finally, Don Kennedy got involved, and they put a lot of resources on the table in order to develop a program at Stanford that I thought would be a really unique opportunity to have responsibility for a smallish, fairly defined academic program in surgery, where I could really train future academic leaders, take advantage of the rich research environment at Stanford, and also maybe work with them on developing a cancer center. I'm proud to say that we did start working on that when I was there and they just competed and were site visited for their first core grant. They have a beautiful facility that's been constructed there.

About the time that I went there, the indirect cost scandal hit. As a result of that, Don lost his job as president, and a new president was recruited to Stanford. That particular individual didn't have the same view of the medical center and excitement about having a medical center. David also lost his job as dean, and suddenly I found myself in a position where the people who brought me there weren't there anymore. There were a couple of pretty tough issues for department chairs, and I guess being the department of surgery chair, I often found myself as the point person for the other chairs, a person the other chairs were turning to for leadership.

One very significant [issue] was the practice plan that we had and the financial stability of the departments. The new president, the board, and the hospital was able to influence the board to take the practice plan away from the faculty and put that within the hospital. All of us raised our hands and tried to protest, felt that would be a major problem in terms of buildings and collections. I think they struggled with that for a number of years.

The second issue that came on the heels of that was the plan to merge Stanford with University of California, San Francisco. Again, I think that those of us who were chairs felt that was highly problematic and would not work, would drain Stanford of a tremendous amount of resources. Again, I was seen as a vocal leader of the department chairs who were very worried about that.

More than that, I was seen as a close colleague of David's. David had brought me there, and David and I had a great relationship, and everyone knew that. David

was likely to call me on Sunday evening to get advice about lots things, not just surgery issues. I think, more than anything, I was painted with the same brush.

CL: And Wisconsin?

JN: At Wisconsin, they wanted someone to come in to merge two cancer centers. They had two cancer center core grants, one for the McArdle basic science program and one for the comprehensive cancer center. I think that, in retrospect, right from the beginning, they felt that was an interim—they didn't tell me that—but I think they looked at that as a "fix this."

The dean and I certainly did not have a common vision or position on what that center could become and the fundraising of that. We had major issues over my ability to go out and raise funds. He used the power of his office to keep this cancer center from building up a significant fundraising development arm, didn't want us to go into Chicago to raise resources. It may simply have been that he saw that as competition for plans and things that he wanted to do for the medical school, and it was competition more than anything else.

When we agreed that I had done all that I could do under these constraints, his comment to both me and to my administrator was the same, on two different days: "The problem with John is he wants this to be another Johns Hopkins, and we don't want it to be that." That was what I was told.

It was a tough time for me, because it was right at the time that my wife had just died, and I didn't have a lot of stomach at that point in time for fighting battles.

CL: Was there anything you could have done differently in those jobs, or was this kind of a series of unfortunate events for you?

JN: I don't know that I would have taken a different tact at Stanford. I never pounded on the table or drew a line in the sand or anything like that. I just tried to provide honest, good advice at Stanford. I don't think there's anything I would have done differently.

I am a person that, if there is an elephant with a pink foot in the room, I'm likely to tell you, "There's an elephant with a pink foot in the room, and have you really thought this through?"

I think that everything that I have said and pointed out has been true. As great as Stanford University is, Stanford has always struggled with its hospital—it's clinical operation—from the standpoint that it moved from the city down to the Palo Alto campus with an arrangement with a private practice group that has always, much like Yale, constrained its ability to develop and grow as a true, vigorous, academic university hospital. You can talk to anybody there now, and they can tell you there are still lots of problems and issues they struggle with.

Phil Pizzo, you know from his days here, and from Boston Children's, has been a tremendous new breath of fresh air, new leadership, at Stanford. As a result of his going to Stanford, I was invited to come back and be part of their external advisory committee for their cancer program prior to coming here.

CL: And Wisconsin, anything you could have done differently?

JN: I still think that Wisconsin needs to invest. I think it's got tremendous opportunity, but if it doesn't allow itself to grow, it will never achieve its potential. I think that fundraising and philanthropy is a big part of leveraging of cancer institutes in this country. If you looked at some of the similar university-based cancer centers and said, "How many people do you have working in development for your cancer center?" and then compared it, you would see that there's a lot of weight placed on that, and that's how you make your advances and do the kinds of research programs that you want to do.

I don't know that I would have done anything differently. All I did was try to articulate that and push that forward. I didn't fight with anybody about it.

I would follow that up by saying you could call a couple of department chairs. I stepped out of that position, and shortly after that, the chair of radiology, who had only been there a few years, threw his hands up and stepped down from his position. The chair of medicine, who had been there less than I had been there—he had been recruited from Philadelphia—he said, "I'm outta here." The chair of pediatrics also quit. The chancellor, John Wiley, stepped in and said, "Enough is enough." They just recruited a new dean. So, you can put it all on my shoulders if you want, but I think it's more complicated. Academic things happen that way, and you don't have a lot of control over it.

CL: Moving on to NCI, how would you summarize the institute's financial condition and your plans for managing resources?

JN: We finished the so-called doubling in 2003, the significant increase in the budget between 1998 and 2003. In 2004, we had a little increase which covered inflation. From 2004 to 2005, it was essentially flat, which means a 3 or 4 percent decrease. From 2005 to 2006, more of the same, probably took a little over $150 million out of the budget. We are still working with that budget, winding down this month. It looks like 2007 is going to be certainly no better, if not a little bit worse.

I remind people that you look at that number

that comes across in newsprint as the appropriation, but sometimes you miss what is the take-away part of the budget. After the appropriation, Congress took a 1 percent across-the-board swipe at the budget. There are a lot of taps or chip-aways of the budget that go to support HHS, that support NIH, automatic off-the-top. Federal increases in salaries, increases in utilities, come out of that. A lot of things are pretty fixed and come right off the top.

The RPG pool, which is a long-term commitment, comes out of that and you're left with a little bit of discretionary budget to use in ways to keep that momentum going forward.

So, what have I done? I got into this in the middle of last October, when we were beginning the continuing resolution, and what I talked to the Executive Committee, the heads of the divisions, was saying, we can't just keep taking so much off the top and sucking the oxygen out of everything. We've got to try to do our best to work as a team. So, I asked them to agree to come together, to take their hats off in terms of their own divisions, and try to look at the programs and projects we were supporting through our divisions, as NCI leadership, and to try to make hard decisions about what could we begin to phase out, what had outlived its usefulness, what would we like to do, but just can't do. A lot of people came to me afterwards and said, "Gee, this is the first time we looked at each other's budgets." We looked carefully at the programs, and we've tried to work together as a team. So that was pretty well received last year, and we are doing the same kind of process this year.

CL: Are you going to be issuing a list of what's funded or not funded? You talk about this process a lot, but I don't see the result.

JN: No, I think that some things will obviously, by their very nature, become public, but I don't plan to make any list of things.

CL: Are there programs that will be protected from cuts, or is everything on the table?

JN: We tried to put everything—we even, they tell me, for the first time, we've gone through all of the infrastructure, in a series of meetings.

We have gone through the so-called Office of the Director. I think the Office of the Director is a large garbage can. Everything gets dumped into the Office of the Director over the years, and I've inherited all of these ideas and wonderful thoughts that people have had for the past couple of decades.

Part of this is education for all of us. Nobody's taken the lid off and peaked inside and said, "What are you really trying to do in this office?" Maybe it actually needs more resources. Maybe we should be doing more in that particular area.

CL: Do you see making big changes in the director's office?

JN: I don't think there are going to be big changes. There are certain things that are mandated that we're required to do, and we need personnel in place to carry those things out. We are going to try to do a little bit of consolidation. The budget is about 5 percent of our overall budget, which isn't bad. That's about what infrastructure is in a big organization, so I don't think that number is far off—it's not outlandish. But maybe we can consolidate some things. I think there will be some changes. There won't be huge changes. Some of the big numbers that you'd like to get at are facilities and rent, when there's not much that you can do about that.

CL: Are you going to hire a replacement for yourself as deputy director for clinical and translational sciences?

JN: No. I think you've sensed that I've moved away from—what was it called?—the Senior Management Team concept with a number of deputies. We moved more toward the older model of the institute in which the division heads, the center director, interact directly with me. We have regular meetings together and separately, more like the other institutes function, and more like the NCI has functioned historically.

CL: What does that mean in terms of existing deputy directors?

JN: Dr. [Anna] Barker [deputy director for advanced technologies and strategic partnerships] is very, very much a scientific colleague and a big help in managing some of our initiatives in nanotechnology and things like that, but I'm very much involved in that. That's not delegated, it's very much a partnership, working together with her to carry out some of these things, where we work with other institutes, the genome project, things like that.

CL: Will her function change?

JN: I don't know that I want to say that her function has changed, as much as maybe she has a different relationship with me than perhaps she did with Andy. We are working both as scientists. Does that help?

CL: If you could provide more detail…

JN: It's also evolving, but I think she's happy and content with the way things are going, and we are working well together. I think we work effectively.

CL: What about Dr. Mark Clanton's role [as deputy director for cancer care and delivery systems]?

JN: I think he's kind of feeling his way with things,

with what he would like to do in the system.

CL: You've proposed the NCI Community Cancer Centers Program, an ambitious program, while there are many existing programs at NCI, including the Community Clinical Oncology Program, the cancer centers, and cooperative groups, that would seem to overlap. How is this different? And, why now?

JN: This is something I've been working on for the past year. As I said at the National Cancer Advisory Board meeting, clearly the cancer centers program is unique to the NCI. Often, prior directors tout it as the crown jewel of NCI. I certainly do. I was a center director. I've served on the parent committee. I've been a reviewer, and I've been around a lot of cancer centers. It has always been, and continues to be, the mainstay of the NCI. Over 60 percent of what goes out the door of NCI in terms of supporting extramural research, is as you would expect, in the centers program. That's probably the best statement of its value and accomplishment that anyone could make. The SPORE program is the same way, in the cancer centers. That's because, in the structuring of that, we have empowered them to bring together the scientific faculty of the institution. The structure has been effective in huge ways.

We really have to put as a high priority, not just on our scientific discovery and understanding the biology of cancer—obviously, that's kind of the yellow line down the road. But, we also have to be cognizant of how we utilize that new knowledge to effect a better outcome for this disease.

I talk about the fact that we have what I would describe as a chemical space. We're working on that, developing that capacity to look at every chemical structure there is to understand how to design those molecules, to re-engineer them, to look at them in multiple dimensions, and so forth. And then, we have a biologic space, in which we are working hard to understand the biology of cancer, the genetic defects that comprise this disease and the stages of this disease, the signal pathways that become abnormal, the issue of cancer stem cells, the issue of the microenvironment, and how all of this works together. And then, we have the translational space, in which we eventually in this continuum get things to begin to test in animal models and in humans. Part of the effort that we need to be making is how do we better integrate these spaces?

A lot of this integration is very dependent on technology and technology development. I see our investment in technology development and in bringing together the physical sciences and the biological sciences as a way to better integrate that continuum from across those spaces.

The net underneath all of this is our ability to do computational biology, apply mathematics to these issues of management of large databases, and be able to manipulate these databases, and move those databases, and assay those databases, to get the information back out. That's informatics.

It's important that we work on that, because we have to make this process faster, and, therefore, as we make it faster, less costly.

CL: That sounds very complicated. What's the role of small community hospitals?

JN: The biggest problem I think that we will face as a country is not our science and our ability to do this, but we don't have the ability to deliver this to the people where they live. I've said a number of times that 85 percent of patients with cancer get their care not in our big university hospitals, but in the communities where they live. There are lots of reasons for that.

We have to be working on the issue of access as well. Not that we are in the business of delivering health care. We are in the business of doing research. Just like you said, we have a lot of programs that are actively involved in asking those kinds of questions. Some of those are health disparity questions, some are navigational questions, and we have programs out. But, I think you would agree with me, they're scattered, not very well connected or integrated.

I've had great response from my people inside, who have met religiously and regularly with me in the planning of this, we call it our guiding coalition on this project. Bob Croyle and his team, Sanya Springfield and her team, Peter Greenwald, everybody, has been willing to come to the table, and with great enthusiasm about this. We have said that in some way, these sites will be laboratories in which we can bring these various programs together to learn how to better do them in the community setting. That's education; that's outreach, prevention, education at the physician level, education at the patient level; that's overcoming those feelings in minority populations that keep them from taking advantage of prevention programs.

It's about bringing this new era of science—the ability to highly characterize patients, highly characterize tumors—bringing that to people where they live.

We grew the cancer centers and university programs back in the '70s and early '80s, because we had to manage toxicity. We didn't manage toxicity very well in the community setting. We didn't do bone marrow transplantation in the community setting. We

managed it in the large centers.

As we are making this transition to highly characterized patients and patients' tumors, and molecularly-targeted, less toxic therapies, and regimens of therapies, we need to figure out how we are going to get that to people where they live.

We also need, as part of this continuum I just talked about, to develop a better mechanism of early-phase testing. One of the reasons we are focusing on hospital-based programs is that we wanted to develop electronic medical records as part of this. We felt that if we can help at the grass-roots level to push this along, we can connect these patients as a cohort—some patients on the screening and prevention side, all the way to patients who are in active treatment, all the way to survivors. So, now we've got a cohort. As part of the some of the other things we are doing that we haven't had time to talk about today, and we'll talk about over the next couple of years, we will be able to go to industry, or industry will be able to come to us, and do one-stop shopping.

CL: You are talking about taking a contract research organization approach?

JN: In a way. You can come knock on this entity's door, and instead of having to go out and negotiate with 10 different places to try to do a very complex study that might involve more than one molecularly-targeted therapy in the new era, you may be able to come in and within a day, work out all the particulars, sign the contracts, and have this open up not one place or two places, but across the country. At least that's a goal and a vision. It's grandiose and it's big, but if we can work towards that, I think we can greatly speed up this process.

CL: US Oncology does similar things now.

JN: And we put a person on the [NCAB], Lloyd [Everson], who is from US Oncology. So you can see where we are moving.

CL: Why start with a colon cancer study?

JN: Don't over-read that. We just thought we needed to put something down as an example of what one might do. If you read the words carefully, I think it's "might do something in colon cancer as a model." We felt like we needed to give some models that might help people who might be trying to decide, do we want to apply for this?

CL: So, each site would be focused on a specific—

JN: There is no strict feeling that you do this or you do that. It's more of an example.

CL: What was the reason for bringing it to the NCAB, rather than the BSA?

JN: There is no real reason that it needs to go before—because it's a contract mechanism, and it's a pilot study. It wouldn't technically have to go anywhere, but my feeling was, again, of transparency. I wanted to bring this to the NCAB. I wanted them to either tell me, "Whoa, Niederhuber, you're absolutely crazy and you shouldn't go down this road." I wanted to see what their level of enthusiasm was. I tested this out, and everybody I tested it out on was, "Wow, this is exactly what you need to be doing." I also tested it on center directors and some of the members of the BSA, and we'll talk about it at the BSA as well.

CL: Why start this through a subcontract with SAIC [the contractor for NCI-Frederick]?

JN: It's the easiest mechanism. They have the expertise, they have the manpower. They are just super. It's a real simple, easy way to manage this and get it out there, go through the right processes. They have a wealth of experience in doing these kinds of things.

CL: One of your predecessors got into some trouble over the use of SAIC. [A House oversight committee is investigating former NCI Director Richard Klausner's role in awarding an SAIC subcontract to a laboratory at Harvard University.]

JN: For a single contract. This is going to be multiple sites. I think that's the difference. We are trying to go through all the legal steps, to be sure we're not doing anything that's not.…

CL: Why not use a cooperative agreement or grant mechanism?

JN: The plan is that what we learn from this experiment, in our pilots, will guide us in the crafting of the RFA. We have programmed this for three years, and the hope that is out of roughly six or so sites, that we would learn enough as this is working. I hope we will learn a hell of a lot on how better to do this from this pilot. From that, we'll craft an RFA.

CL: Skeptics out there might say that this just an easy way to bypass rigorous peer review.

JN: The pilots will be peer reviewed.

CL: Would the BSA vote on this concept?

JN: They are welcome to vote on it if they want to.

CL: You'll ask them to? They won't vote on it unless you ask them to. Would you ask them?

JN: I don't have any hesitancy. I haven't thought about that. I think that everybody sees the wisdom of this and the importance of doing this. I think it's not a question of whether we need to do this. I think the question is how best to do it. When I've been asked, when certain things come up, down on the Hill for

instance, "How are you getting scientific information out to the people in my constituency where they live?" I've said, "Look, we've got a plan." The eyes around the table light up like saucers and say, "Yes! Now you guys are finally addressing and thinking about the real issues."

CL: What are the deliverables for this?

JN: I've said the deliverable is access. It's about bringing the science of this new age to the people where they live. That's what I would like to see.

CL: How would you describe it in terms of contractual matter? If I'm applying for that grant, I'm asking, "What is my deliverable, Dr. Niederhuber? What do I do?"

JN: I think there are multiple things that we put in that we would like to see as deliverables. We said we would like to incentivize multi-specialty approach to care, because we think that will elevate the boat of the quality of care. We said that we want to bring early-phase clinical research to these patients. CCOPs is great, but you know and I know that CCOPs is testing multiple drugs against multiple drugs, the phase III kinds of things. We are going to have to move much more rapidly into these molecularly-targeted therapies, and we are going to have to figure out ways of getting these early studies to people, not just a few people in 60 cancer centers across the country. That's a deliverable.

Electronic medical records is a deliverable. Outreach, education, is a deliverable. Developing partnerships and relationships with the state public health departments and the regional public health departments, to me, that's a deliverable that's important.

We are really leveraging; we are not putting a lot of dollars into this. In many ways, it's the NCI saying, "You can be part of NCI's game." That's a different opportunity for people in the community. I think they are very excited about that.

CL: When we look back at the Niederhuber stewardship—

JN: After you've run me out town?

CL: Well, in 2015—

JN: I hope I'm still alive.

CL: —what will it have been about?

JN: I hope it will be about having been—saying, "He was honest. He was open. He worked as hard as anyone could work towards trying to enable the cancer research community to do the work as hard, to have the resources to do as good a job as it possibly can to move us towards driving that incidence rate and that mortality rate down."

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