

In Business LAS VEGAS

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Dr. John Ruckdeschel is ready to take Nevada Cancer Institute to the next level.

He's an oncologist specializing in lung cancer who figured out his profession is better served if it is run by physicians with business sense, rather than accountants and lawyers. He took some courses in business and management and, several years later, was asked to establish a cancer center in Albany, N.Y. He moved to Tampa, Fla., to run the Moffitt Cancer Center for 10 years, building it to the third-largest cancer center in the country. He went on to the struggling Karmanos Cancer Institute in Detroit, where he successfully reestablished the institute's much-needed federal funding.

Nevada Cancer co-founder Heather Murren, and her husband, Jim, asked Ruckdeschel, one of the institute's early consultants, to take over its reins earlier this year.

IBLV: Moffitt Cancer Center was a startup and you turned around Karmanos Cancer Institute in Detroit. You have a penchant for taking a challenged cancer institute and improving it. What's your secret?

Ruckdeschel: I think that if you look at the best hospitals, the health plans, the areas, that all of us agree are the best, very few people would argue that Mayo Clinic isn't one of the best overall health care institutions in the world, or (Johns) Hopkins (University) or Duke (University) or MD Anderson (Cancer Center). The thing that characterizes every one of them is that they are run by physicians. Now they are not just average physicians out there trying to maximize their return and their profits and how many patients they can see and on Thursday afternoons (they are) out for golf and all this other nonsense that is alleged to happen. Doesn't happen much anymore, but is alleged to.

But they are run by physicians and physicians who are trained and who understand business and who can make hard decisions. But at the end of the day the decisions that they make are guided by sort of that core belief that there is something very special about that relationship between a patient and a physician. That is a sacred vent and the system needs to make that happen well and not get in its way. It's making sure that the radiology technician, the billing clerks, whoever is in the organization who have their little piece of the bureaucracy — yes, we have to get this approved by the insurance company before they can be treated, etc. — they have to make the process flow in their part of it on the edge, they can't keep getting in and stopping the process. They can't keep making the doctors do their work — “Well, doctor, you have to call the insurance company.” — No,

that's wrong. It's rare that I should ever have to call the insurance company. That can be handled on the staff level.

It's getting the whole organization thinking that way. And, really, it's not hard. Most people want to work in that fashion, but don't necessarily have a road map on how to do it. I think that's where it comes from. It's applying being a really good physician and a good businessman and then being able to put those principles together. It's just critical, and I think people who deride that because that's business, that's not science, or medicine — that's nonsense.

The nuns I learned from early on — one of the first places I set up in was New York at St. Mary's Hospital — and the nuns taught me well there. No margin, no mission. If you run the place in the ground and there's no money, you're not going to do any science and you're not going to give very good patient care, no matter what. You're not going to be open as a matter of fact. You have to balance those things. It's that balance. How do you get great science, great medicine and a lot of good business, a great business besides, that makes a place great? I don't know why, some people can play a musical instrument. You either have a love for organization structure, how systems work, or you don't.

What drew you to the Nevada Cancer Institute?

Well, partly the history of it. I had been there on the early consultation and suggested the direction they chose, which is a free-standing research institute, and I think for lots of reasons — historical reasons — every state university system in the country struggles. It struggles with resources, it struggles with legislators, with different agendas imposing one or another set of rules on them, and the constant flip-flop between high quality and high numbers of in-state students going. They're pushed and pulled in a lot of different ways. It's very clear to say, you have to be affiliated with the university and deeply integrated with it, but not under it. I'd seen them do that. I sort of watched (Nevada Cancer Institute) grow up a little bit, and it's a challenge. That's what I do.

What is the toughest business lesson you've had to learn?

How to fire people. Any fool can build. You have unlimited resources, you have space, you can hire whoever you want, or get consultants, do whatever the stuff you want to do. (But) when the money gets tight, or when someone's not doing a good job, firing them is the hardest thing to learn.

In academics, we're not taught that. In medical school or university, if somebody's a complete dud (and) just can't do their job, one of two things happens.

They may be a lousy doctor, but they're a good teacher, or they're a lousy teacher but they're an OK doctor. So we move them to the admissions committee or get them out of the way of where they are now. You wind up with an organization with little pockets of festering people who are ticked off they got pushed aside years before, and they just sit there quietly collecting their tenured salary, mucking up that part of the organization.

You can't do that in business. And, so, it's very hard to have to bring someone in and say, "this isn't working. You need to leave the organization." Because it's the only way to make it work. That's hard. That's not a skill set that we're brought up with in medicine or in academics. But it's the key one to learn. Once you can learn to do that with some dignity for the people involved and some "there but for the grace of God go I approach" to it, you get to do it.

You never like it. It creates a certain loneliness in this job, because normally the people that you would play with — you go out and play golf with or go to dinner with — would be the people you spend a lot of time with at work. Everybody but the boss gets to do that.

I've had to bring in someone who I hired in the past, or who has worked for me for years, who at a certain point in the organization's growth, they just can't grow any further with it. I mean, they themselves just can't get to the next level, and the organization needs them to, or needs someone in that position to be able to do that.

That's the hardest thing.

Fundraising has been tough this past year. What are your plans to counteract that?

I thought what we would do is get more of us trained in blackjack and craps and start working on the endowment that way. You can do fairly well (laughs).

But we're waiting it out, as obviously we have to. All of our major donors are in the same place. It's not that any of us are poor, we're nervous. Everybody's nervous about where things are and some people have lost real portions of their personal wealth. But they don't give to this (institute) because there's some quid pro quo that they're expecting. They give because I think they were convinced themselves and convinced by the Murrens that a city of 2.5 million deserved to have a first-rate cancer center. That the best cancer care shouldn't be obtained at the airport on their way out of town. That's a bad joke, quite frankly, and I hear it a lot still. Not just about cancer, but about lots of elements of health care in this valley.

That's not appropriate. This is way too big a city for that. Quite frankly, it is now twice the size of Detroit. Detroit's down under a million people now. They're all in the suburbs, but that's where they used to be. They're all moving out of Michigan now.

I think that's the vision that is out there and I think people still believe in that. Many people have said, "Let this settle down and I'll be back to the table." A few people have asked to sew their gift up a little bit. We've tried to be more responsible by saying we won't have as many events. We'll bring them down in numbers so we're not putting demands on people who are struggling.

It hasn't shut off at all. We have several significant gifts and as we know the Lincy Foundation just gave us almost \$3 million to do the renovations down at (University

Medical Center). They gave us another \$10 million, which will be announced shortly for some of the hospital development work we're doing. Another one of the board members gave us a million for (a cancer research chairperson). So it's still there, it's just not quite as low-hanging fruit as it was several years ago.

How much state and federal government support have you received and are you disappointed in the level of support from each?

(The National Institute of Health and) government support has been interesting. We've had excellent government support and our congressional delegation has been very supportive in seeing to it that we have access to those congressional-directed funds. We've done quite well. Several millions of dollars in that area and we'll continue to do well in that area. Increasingly, as we bring on more faculty, we'll have \$5 million or \$6 million in grants each year they're coming in, so that's good support.

It got a little hairy in the last few years of the prior administration, where they just stopped funding the growth in science. It wasn't even failure to keep up with inflation, they were just true cuts. The amount of funding was dropping dramatically, and it was the real crisis in the field. That's reversed a fair amount now, and I think that side will be OK.

I think that the state has been a bit of a disappointment, but understandable. The state and its residents — us — have chosen fundamentally to be a no-state-tax entity and therefore very reliant on revenues from the tourist industry. Having spent 10 years in Florida, I'm very familiar with the ups and downs. As that industry goes, so goes the state budget, on a regular basis.

I think this has been deeper and more profound than many people thought, so it's hard to criticize the state for cutting back funding, but I think ultimately there are certain core services the state needs to provide, but there are also things the state needs to invest in. Certainly, if we're going to grow the state and we're going to grow the city, then investing in the educational institutions and the research institutions is critical. UNLV, UNR, they need more resources. They need to get stronger. You can quibble — I read in the newspaper today UNLV get unfairly criticized — let's not argue about how they did the study, or what was included or not, let's make UNLV so much better that it's not anywhere near that part of the list and it's never a point of discussion anymore. That's going to require state money and that's going to require us doing it.

I met the new chancellor (Daniel Klaich), I'm excited. I think he's got the right approach to it, I think Maurizio Trevisan (executive vice chancellor) at the higher education system has an outstanding broad view of things. I think they are making some really good head starts. We're participating in that. We're very actively involved with them right now.

I think places like Nevada Cancer Institute, the Lou Ruvo Center ... are the kinds of institutions the state needs to make an investment in, and not "We'll give you this if you do this project (and) show us six jobs you got with this." It needs to be something where

they say, “Wait a minute, this is for the long-term health of the state.” This institution will attract over the next several years, several hundred in faculty and researchers to the area, and their staffs and their families, and be a really major contributor to the local economy. As the Ruvo grows and as UNLV grows in town, the interplay between the organizations, things will begin to happen.

If we take another example: One of things Nevada is very proud of, and rightfully so, is the Desert Research Institute. Well, we’ve modeled our interaction with the state very much after their interaction with the state ... We’re mutually supportive, but fairly free-standing in operations. They come at this from the environmental side, and where they’re coming now is, “Wait a minute, all these environmental things that we’ve studied so incredibly thoroughly, have health effects.” Their beginning to poke into looking into recruiting faculty who understand what’s the effect of the various things like radiation or water and air quality and their effect on the human being. That’s wandering into our field of toxicology, where we understand what happened to the people, now what it was in the environment that was causal in that.

What you will see — and hopefully the state would see fit to support that — is as the crisis gets over financially, is to say, “Wait a minute, what a unique opportunity to put two of the state’s star institutions together and be supportive of some joint recruiting in that area and bring people in that area.” I think it will happen. It would be imprudent, if not just unfair to be ranting and raving that we have to have money when the state doesn’t have it. There are some realities we have to face. But as the money starts to flow again, as the tourists start to flow again, and as that recovers, we need to be thinking about where we’re going to put that money. Are we going to set some aside, are we going to invest in these? In Florida, the Legislature put aside \$10 million a year for the cancer center. That was spectacular. That was the new research recruitment budget every year. We could do a lot with that. Whether it’s \$2 million, \$5 million, \$10 million, it’s very real, because other states are investing in their cancer centers. Many of the states: Pennsylvania, Georgia, Texas, obviously have invested heavily in their cancer operations and that’s what we’re competing against. We don’t compete against the private groups in town. I mean, we do, but not at that level. The people we’re competing with are the national cancer centers and if they just got \$10 million from their state, they’re going to use that \$10 million to go after the same scientists that we are. You can guess what the expected outcome is.

I think the state will need to do more, don’t expect them to do it right now, but I think we need to be part of how we solve it, which is why I was very excited to get on this panel that the (Clark) County Commission has set up about how we get out of this (economic) crisis.

What committee is this?

It’s the (community priorities committee) and they asked for volunteers. (Commissioner) Susan Brager put me on this. It looks at how can we save on money, how can we spend the resources we have in a way that makes some sense. And obviously one of the things

we have to think about is health care. Do I need another thing to do? No, but if I'm going to sit here and ask the state for money, it'll be a lot stronger argument if I can say "We've been in the trenches for a while and here's how we might do this a little bit better and a little bit differently and spend our money on a little bit better basis going forward," and have a little bit of weight behind it. There's a thread there I think.

It's an old management trick. The person who comes in and complains about the schedule, let them make up the schedule in the future. You know why that works?

Why is that?

Take any schedule, doctors being very susceptible to this on this 24/7/365 basis, and in any given month, you have what? You have several months that have five weekends. Who takes the extra weekend?

The one doing the schedule.

The one doing the schedule, unless they're really stupid and they keep assigning it to other people. When the other people get really mad at him, and they yell about it, and somebody else gets to make up the schedule. The person doing the schedule usually, more often than not, eats the extra weekend as they pump up, etc.

I figured I might as well jump before I get appointed to some of these things (laughs).

How did you increase funding over at Karmanos?

We got the National Cancer Institute core grant refunded. So that went from \$400,000 a year to \$1.5 million a year, right off — brought in more scientists, and that took our funding to \$40 million annually in research pieces and then up until the real profound collapse in the economy there, we were really growing. The patient counts were growing, the services, affiliates throughout the state, running a successful operation, generating revenue that — actually the operations of the institution were self-sustaining — therefore anything we got from the state, the feds or philanthropy could go to the research effort, and there was no need for it to be supporting the operation.

Will you be able to do that here in Las Vegas? And how is fundraising different here? I know there are some challenges different here from other places.

I think they are more style than substance. There is a certain style for how events go on here. There's a certain largeness to the events that I would say is less apparent in Detroit or Tampa or Albany, for God's sake. I'm not sure what to do with an event like the ones that are put on here. But at the core of it, people give to people. If the person you are interacting with at Elsewhere University or Wonderful Heart Institute, if you don't like that person, whether it's the developmental officer or the president — if you don't trust them, they're not going to give money, no matter how much you support the heart institute or whatever you've being asked to support. At the end of the day, that's the same

wherever it is. You have to establish relationships with people, gain their trust, show them what the vision is, show them some results, and then, work with them. Our development staff, which is superb, by the way, really understands building long-term relationships with people. So, you're not just there when you want a big donation out of them. You're there when they call and say, I've got an aunt in Kalamazoo somewhere that needs (help). You do that, you help, you're there for other events and you get back to what's happening. If they donated to a certain program, you give them feedback on how that's done. You nurture those relationships. Same in Florida, same in New York, same in Michigan, and it's the same here. That's the core of the business. The glitter and the other pieces that go with, that differs between areas.

There have been a lot of personnel changes since you came onboard, including the departure of Nicholas Vogelzang, formerly the institute's director. Why?

Well, I was brought in to replace Nick. The institution looked pretty hard and realized that it needed someone who had the business skills. The organization is now at that juncture where all this needs to come together. We need to make enough money on our clinical operations to support those clinical operations, and hopefully spin off additional funds to support the research effort. If you're going to be a national-level cancer center, you have to do great care and you have to do research. You can't do one or the other and be what this place proposes to be. I think Nick was less comfortable in that business role, hadn't had the training and the decision was made by the board long before I ever got involved in this to make a change at that level. I think I know why they did that and I certainly respect them for that. I'm the beneficiary of that. I love being here. I'm somewhat upset that we couldn't keep Nick in the institution, but I think that's understandable. That's it in a nutshell. You either have a passion for making an organization function, making everybody go together, or you don't. There's a set of skills to do that. They're not the skills we learned in medical school, they're not the skills we learned generally as practicing physicians or practicing researchers.

What other changes are on their way, such as projects or initiatives?

You have an hour (laughs)? We have a lot of recruiting going on right now.

Very shortly we'll be announcing a significant joint venture where we'll be forming a free-standing cancer specialty hospital in the area. We'll do that on a campus, which you'll figure out shortly enough. That should be an outstanding addition. We'll then be able to bring in bone-marrow transplants and some of the high-end surgery that can't be done here now, but people are going to McCarran to get. That's one of the bigger projects we have under way.

In addition, one of the things that's missing here, and congruent with where we are thinking as a society, is a center that can figure out who's at high risk, whether from their family history or whether from a certain prior illness or genetics, whatever it is. What is the risk? Age, gender, how they add up together and do the tests to find cancer early and prevent cancer in that group. Get away from processing the whole population when only

a small fraction of them are going to be at high risk. That sort of high-risk family center that looks at all the important diseases: lung, breast, (gastrointestinal) tract.

There's a little bit of a pall over this area and this region. Every 40-year-old white guy who's a little bit overweight and has indigestion is at risk of what's called Barrett's Esophagus, the lower part of the esophagus being dysplastic and changed as you get in cervical cancer. Then you've got stomach cancer. It's one of the fastest rising cancers. It's still relevant because it's rising as opposed to going down ... but somebody needs to figure out who's at risk, because doing everybody in the population doesn't make any sense. That's a waste of money, and everybody's time and anxiety. But if you know who's at risk and you look at them fairly closely, there are lots of things you can find out. A) You can prevent a lot of cancers, or you're going to find a lot of them early, and B) you have unique access for our scientists to (study) malignant tissue because once a cancer is malignant and spread all over the place, so many changes have occurred, you want to know what tipped that first domino over. What happened in that break between irritated and cancer. So, having access, that's a really critical set of tissues we would like to avail ourselves of.

You need to do that in an organized fashion. You need to be able to do questionnaires, genetic counseling, the actual procedures that needs to be done. So, we're busy setting that up there.

In October, we're opening the (Ralph and Betty) Engelstad Research Building. It's the new building on campus here. It's close to 200,000 square feet of research space. I think it's the single biggest research facility in the state, would be my guess. It's only research. There's no offices or faculty or auditoriums.

So, those are the things that we've got going on. And with the recruitment and all, there's a fair number of things.

So you're busy?

I wouldn't be happy unless I was.

The institute has stated its intention to achieve National Cancer Institute designation. Why is this important?

It's what distinguishes you. That's the Nobel Prize, the Pulitzer Prize, if you will, for a cancer center. It's that recognition by your peers nationally that says yes, you have excellent clinical operations, which gives you the playground, or the area, to do the clinical research, which is vital. Now matter how good it is in a lab, until we try it on people it's not ultimately effective. You've got to have that clinical base on which to do it. You've got all these researchers here and you've organized them not by the traditional departments.

Cancer is not a disease of biochemistry or microbiology or molecular biology. It crosses all those boundaries. We like to think of some of the signaling problems or the problems with the blood vessel growth, which brings together scientists from a whole slew of areas together in ways that might not be readily apparent when you do that and are not covered by the usual medical school or university departments structure, per se. Once we've done that and we've created that milieu and generated sufficient outside support from usually federal government sources, we join that rank of institutions that have done that.

Now, it's not many places that can do that. Right now, 41 comprehensive and about 70 overall, NCI-designated cancer centers in the country. There's nothing here. I think the nearest one is probably in Los Angeles. That's our Pulitzer Prize. That's what we go for, a (leading) cancer center. That's what we need to be.

Any idea when that might happen? Time frame you're giving yourself?

Yeah, I'd say five years. I think we can do it sooner than that. I think there's a fairly good head start on the science now and if some of the recruits I'm looking at, I can pull together in the next year or so and give that soup about two years to get together and create those interactions, we might be ready to submit in three or four years. But I'd like to say five years we'll be in. And that's rocket-sled time. Institutions often are 10, 20 years applying for that. The University of Florida still doesn't have a cancer center and their problem is, they're dominated by their university departments. They don't want to give up a piece of the action to something like a cancer center. It causes cuts across all of their departments. So they keep their prerogatives, they keep all their powers and the (National Institutes of Health) looks down and says, "Well, that's not how you do it. Goodbye." So they don't get the (designation).

The University of South Florida, which is where Moffitt is — What, second-rate? — compared to where Gainesville was, it was really the only true university in the state at that level, maybe Miami. Walked all over them because the cancer center was free to operate as a free-standing research institute.

That's what we're able to do here, so we'll be able to get it in a pretty good time frame.

Does the institute's Las Vegas location pose any problems in luring researchers or in gaining credibility?

That is always the case. When I went to Tampa in '92, nobody wanted to move to Florida. Florida was not taken seriously as an academic state. That was Massachusetts, New York, California, Illinois, Michigan. Those were the academic states, or Pennsylvania. They certainly didn't go to Florida. They went there to retire or went to God's waiting room, as we called it. Universities were not in the first rank. Even University of Florida-Gainesville just did not stack up against the Dukes and the Stanfords in the country. And, yeah, it was a problem recruiting initially. But very quickly people came because they saw a research institute that was doing research they wanted to do. Now we didn't help very much in recruiting cardiologists or obstetric

people, etc., but the university benefited from this huge cluster of cancer scientists who developed overlaps in those areas. Some of those other areas prospered and grew as well.

So, yes, I think it is a problem here. Fair or not, UNLV's perception in the academic world is not in the highest ranks. But some things can be changed. It needs a little bit better (public relations) and marketing. But for that, I'm not sure that long ago basketball should be the only thing it's ever remembered for. There's a lot of good science going on there, and I think it would help them to get recognized for that, too.

That will be a problem, and there aren't other universities and technology empires here that we can steal technicians from and recruit away from. We have to bring people in.

There's also a certain sense people have, "Are you serious? How can I raise a family with all these naked people running around here, gamblers and drunks and everything else?" Of course, quite frankly, I have two stepdaughters now, 13 and 10, and we take them down on the Strip and the truck goes by (that reads) "Hot babes to your room in 30 minutes" or whatever it is, and yeah, there's a certain element of that. The 13-year-old asks, "Mommy, what are all these cards with naked women on them here on the ground?" There's an element to that. But as soon as you get out here in Summerlin or Henderson or any of the areas, you realize it's a very nice place to live, and (the Strip) is a confined activity and we all love it, we all partake in it. But we don't live in that. We live in very normal suburbs. If they can get past that, then what happens is people come and they say, "Look, here's a place where I'm not the 14th person in a 28-person department. I can be first or second. I can really grow here." It's something you can't do at Harvard. It's something you can't do because the people have been there a long time, really good people who you're not going to pass. So, that's who we attract, and I think we'll do very well. Some of them will turn out to be stars in their own right, some of them won't and we'll put a bullet in them or whatever. Fire them, I meant to have said (laughs).

What were your initial impressions of the institute's clinical programs?

Young and incomplete. I mean, it's only 2 years old. We have some very good medical oncologists, good radiation therapists, but because we don't have the inpatient facility yet, we don't have surgeons. The teams aren't complete. We work with a lot of people in town in the various surgical specialties and as we open our inpatient facilities, and as we develop, we'll either hire surgeons ourselves or hire some people in town or work out relationships with them. It will vary, depending on the type of surgery.

We know where we're headed. We do things very differently that are done in practice. It's what's unique about cancer centers. I'll give you an example. I just do lung cancer, so I'm used to every week, myself, the other medical oncologist, the radiation therapist, the surgeon, the pulmonary specialist, the radiologist, the pathologist, with all of our nurses and students, we go in a room, we look at the X-rays and the history of every new patient we're seeing with that disease and before anybody does anything to them. Before any of the treatments are initiated, we discuss them. What do we think is best? And the egos are big enough in the room that none of them dominate. Everybody's been to the meetings

and everybody specializes in lung cancer and they know the studies well, so nobody can bamboozle them. Here's the literature, here's the research, we all know it. So nobody gets to run that stuff by. We can also say, "Wait a minute, we have a study that suits this particular patient, so why don't we offer that study to the patient?" We can catch it because we catch it beforehand.

I do that every week. That's better care for patients with lung cancer. Now, if I was out in the community and I was as good a medical oncologist as comes, when I open the door in the morning, I'd see a lung cancer patient, then I'd see a breast-cancer patient, prostate cancer, colon cancer, lymphoma, another lung cancer, breast cancer — I'd take what comes in because I'm a generalist, in that sense. Now, even if I have a profound interest in, and I'm really up-to-date in these, I can't go to 14 different meetings a week (and) getting all those (medical) people together. It's an un-doable feat. Rarely you'll find in a private setting that people will set up a breast center and they'll all fight to get themselves there for that one thing, but they can't do it for all the diseases. It's not doable. So, that's the major difference.

I think there are lots of cancer where you'll never necessarily need all that and most of it can be figured out pretty easily. But there's a whole bunch of areas we can't do — which things to do first, which procedure to do first — and yet as a patient you don't want to be caught in the old hammer-and-nail thing. If you see someone who does a certain procedure, they're likely to recommend that procedure. You just became a nail, whether that's what you are or not, because they're a hammer.

The vast majority of physicians don't say, "Well, gee, I'm going to do the wrong thing for this patient, because I make money at it." Most of them go, "I know how to do this, it works, this is a reasonable patient to do it on." Now when you really understand the disease and get down to the nuances, there might be a procedure that's a little bit better, or a little bit different for this particular patient, but your procedure is OK and so you proceed thinking you're doing a good thing. And I don't mean to ever imply that they're out there just doing this to make money. I really don't believe that for the vast majority of docs out there. Here is the patient, something's already been done before anyone might sit down and talk about what's happened. I think that's not as good as having it discussed prospectively. That's where we're moving, that's what we're recruiting for, that's how we have to structurally set the institution — how we assign space, and how we have our clinics set up, it has to support that.

And on the same note, what were your initial impressions of the research part of the institute?

Pretty strong for such a young institution. There's about 10 or 12 researchers here who are applying and getting funded and doing a nice job. This is a strong group in drug development and a growing group in what I call cancer stem cells or tissue regeneration work. Actually in any given cancer, there's only a handful of cells capable of regenerating, and those are the dangerous ones. They behave differently from the ones that are more differentiated than that. How true that all is and how widely applicable it is

and how to take advantage of that is all under wide-open study right now and it's changing monthly. We have a number of people who are actually doing some very exciting work in that area.

We do need to recruit people in what is called population science: That's epidemiology, behavioral areas and probably some broader basic sciences, molecular biology or what we call cell signaling. But that's what we're working on next.

As a lung cancer researcher, will that disease take priority in the institute's research?

I don't do lab work anymore, but I certainly put patients on studies and participate in the research.

Normally it wouldn't because my belief is that if a new director comes in and then promptly puts all the resources into his own area, that's a really bad message to send. It turns out, however, that the Engelstad family is extremely generous to us and particularly focused in the area of lung cancer. So, yes, it will be one of the areas that we develop. We've already got other areas under way, but that will be one of the ones.

And you have to. As a cancer center you have to deal with lung cancer, colon cancer, prostate cancer and breast cancer. Those are the big four. Those are the ones that affect the most people, and you've got to be able to deal with those diseases. That's why you've got to have strong teams in all of them.

What community outreach will the institute likely continue?

I think you'll see, without giving away any details, some joint ventures and working relationships in the valley here — a number of them — both with people in the cancer field and people in the more general medical area. We're in the process of discussing an affiliation with St. Mary's (Regional Medical Center) in Reno ... we'll probably establish some sort of arrangement with them, and probably in Elko as well. We'll probably look down in Boulder City as well. Anywhere there is a population of anything other than groundhogs and scorpions, where there is a cluster of patients. If we can work it out so that the physicians in that area can see most of those patients, they can come down here for a second opinion, the vast majority will be treated back there. The only ones that would stay here are the ones who need to. That way they don't need to go to Salt Lake (City), they don't need to go to Los Angeles. They're going to get the right care (in Nevada). They may have to go to one of those places because we don't have something in the state, fine, but I would expect in about 15 months we'll have a bone-marrow transplant unit up and running so that anyone who needs a transplant doesn't need to leave the state.



Sam Morris

Dr. John Ruckdeschel, director and CEO of the Nevada Cancer Institute, is shown May 26.