Cancer Doctors Are Making a Fortune Off Drug-Trial Participants

Physicians stand to earn big money when signing up patients for drug trials. And lately, some of those trials have been producing dubious science.

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The future of cancer drug research just might be in Omaha, Nebraska, between a Panda Express and a Mattress Firm.

Here, in an otherwise unremarkable storefront, a little-known clinic called XCancer has become one of the most trusted research partners of pharmaceutical companies seeking to test experimental prostate cancer medicines. XCancer and its sole physician, Luke Nordquist, have participated in more than 200 trials over 15 years, and played a leading role in testing Novartis AG's widely advertised blockbuster, Pluvicto.

A big draw is speed: Nordquist says he can open a trial in as little as two weeks, unlike big academic research centers that take several months because of layers of management and lengthy internal review protocols. "They come to me first," Nordquist says of the drugmakers.

The Omaha clinic is emblematic of a larger shift. Increasingly, privately owned clinics like Nordquist's are the engine room of a fast-growing, lucrative and, for many patients, little-understood business. So many trials for so many cancer drugs are now underway — 2,400 recently compared with 400 in 2000 — that drug companies by one estimate spend $80 billion a year on clinical trials in oncology.

Patients are the customer for all these new treatments — but they're also the product.

Drug trials offer people with cancer hope and free medicine, and open routes to new profits for pharma companies. But the flood of money is also creating incentives for doctors to sign up patients for unproven treatments and at times bending traditional research norms.

Clinical trials involve elaborate protocols meant to set out objective criteria for comparison. In recent years, many trials are "loading the dice" by comparing their new treatments to inferior options or excluding some of the most potent existing treatments, says Ian Tannock, a University of Toronto emeritus professor who pioneered new chemotherapy drugs to treat advanced prostate cancer.

The gambit has a name – the "straw man" control group.

"When you are putting a $100 million bet down, you want to maximize the chance you will see a benefit," says Christopher Sweeney, an oncologist at the University of Adelaide.

As the boom in therapies runs headlong into a finite universe of patients, the rewards for clinics have soared. Drug companies can pay $250,000 or more per patient in major oncology trials, says Tim Opler, managing director of global health care at Stifel Financial Corp. Less than a decade ago, one study estimated, the average was less than half that.

Disclosure rules haven't kept pace with the new financial realities. While drug companies have long courted doctors with consulting fees and other payments – which are disclosed – gaps remain when it comes to clinical trials. Doctors have no legal obligation to inform patients when their clinics receive compensation for enrolling them in trials, and several participants around the US told Bloomberg News that their doctors, in fact, didn't. They're not the only ones flying blind. Two oncologists who have reviewed drugs for the Food and Drug Administration say they were alarmed to learn such payments had become a major source of revenue for many clinics and hospitals.

While there's a popular belief that each new experimental drug must be better than the last, the alignment of researchers and pharmaceutical companies hasn't reliably produced ground-breaking therapies. Fewer than half of the cancer drugs approved since 2000 have been proven to prolong people's lives, a Bloomberg analysis found. Some studies show the average cancer trial might add weeks to patients' lives, often with serious side effects.

Dan Odorisio, a youth basketball coach and former drummer in Omaha-area bands, sought out XCancer following his prostate cancer diagnosis a decade ago. After years of traditional therapies overseen by Nordquist, Odorisio's cancer metastasized. He tried Pluvicto soon after it was approved, then enrolled in trials for two experimental drugs from AstraZeneca Plc.

Nordquist often goes by Dr. Luke online, where he's posted photos of his fiancee (an XCancer front desk secretary turned company president) and son (head of an XCancer-branded racing team). He also shares photos of his patients. In a post to LinkedIn, Nordquist lauded Odorisio's "willingness and courage" and included a photo of his patient. A medal hangs around his neck that says, "1st in World, XCancer."

Contacted after reporters saw the post, Odorisio said he didn't recall any discussion with the doctor about the clinic getting paid for the work. Two former XCancer clinicians who regularly participated in visits say they couldn't recall Nordquist telling patients about the center's trial compensation. Nordquist says he discusses it with "every patient that goes on a trial."

Odorisio's prostate-specific antigen levels, a cancer marker, spiked during each trial, indicating his condition had actually worsened. He volunteered to share his medical

records with Bloomberg. “I lost time,” he said in August, holding back tears. “In my mind, I lost a year of stopping my cancer.”

Nordquist learned his trade at one of the world’s premier cancer institutions, Memorial Sloan Kettering Cancer Center in New York. He’d landed a plum oncology fellowship there but says he found the bureaucracy of a major research hospital stifling. “I’d rather be a landscaper,” Nordquist says.

A group practice in Omaha was equally unfulfilling. Most patients, he realized, have no way of determining if one doctor is better than another. “Having a clinical trial that another center doesn’t have is a marketable difference,” he says.

Trials are a “win, win, win, win,” he says. Patients get access to new therapies for free, pharmaceutical companies get fast and accurate trial results, his small business gets income and society gets more drugs faster. “I’m your guy in the trenches,” Nordquist says he tells drug sponsors.

He started what was then the Urology Cancer Center in 2010. Trials became the unique selling point of the new venture, later renamed XCancer. At first, he scheduled appointments with patients from the unfinished basement of his house.

After starting with three employees, Nordquist now has more than 60. They manage both a research arm that works with drug companies on trials and a routine practice that sees 450 prostate cancer patients and 25 to 50 with other types of urologic cancer each month. He’s still the only physician. “I don't have a lot of people telling me what to do here,” he says. Three nurse practitioners who report to him also see patients.

“No other oncologist in the U.S. has access to as many innovative clinical trials for prostate cancer than Dr. Luke and his XCancer Omaha research team,” the clinic’s website advertises. For patients facing a grim prognosis, the appeal is obvious: “More hope, more time,” it says.

Nordquist doesn’t disclose the company’s annual sales, but its success has helped fund a Cessna 441 aircraft painted in blue and gold stripes, branded XCancer Air; sponsorship of XCancer Motorsports, the car racing team helmed by his son; and, for charity, a residential complex for cancer patients near a hospital in Tanzania. A 2023 divorce settlement showed Nordquist had an annual personal income of $2 million. “As the only owner, you take the risks and hope for rewards,” he says.

Thanks in part to research funding, Nordquist adds, he’s never sent a patient to collections or had one file for bankruptcy due to medical debts.

Other investors see opportunity in clinical trials. The drug distributor McKesson Corp. in 2022 combined its cancer research unit with Sarah Cannon Research Institute, a

Nashville-based researcher. McKesson has said the venture had a role in 70% of adult oncology drug approvals last year by the FDA; it brings together more than 1,300 physicians at 200 locations in 20 US states. In February, McKesson's chief executive described the company's oncology division as "one of the central growth pillars for the business." In a recent investor slide, the company noted that cancer clinical research had a "higher margin" than its main drug distribution business.

As recently as the 1990s, most cancer trials were federally funded, says Joseph Unger, a health services researcher at Fred Hutchinson Cancer Center in Seattle. Drug companies now provide most of the money and direction. Annual enrollment in industry-sponsored cancer trials more than doubled to almost 120,000 patients in the five years through 2022, compared with a decade before that, Unger and colleagues found in a 2024 study. Enrollment in federally funded trials was largely unchanged at around 15,000 patients a year, a gap that's only likely to grow with the Trump administration's cuts to federal support for research.

From late February to August, the National Institutes of Health terminated grant funding for 118 cancer trials, representing 1 in 37 oncology trials it sponsored, according to an analysis by Harvard Medical School researchers. Such terminations had been rare.

Private investment has brought important new treatments. But industry sponsors typically aren't interested in some kinds of studies, according to Unger. Among them: testing combinations of old drugs from competing companies, finding out which medicines work better than surgery or radiation, lowering the dose — or not using a drug at all. "A lot of questions that would be of interest to patients may be going unanswered," Unger says.

Trials are attractive to medical centers in part because they get paid for every step, from office visits to administering drugs to research-related scans. It isn't just privately owned clinics benefiting from the largesse. Industry payments related to cancer drugs at 51 US cancer centers, such as MD Anderson in Houston and City of Hope near Los Angeles, doubled from $482 million in 2014 to $972 million in 2021, one study found.

The money can send researchers' stars rising. They work with drug companies to help design studies, then announce the results in prestigious journals or conference keynotes. The research is monitored at each center by an institutional review board, typically a group of medical professionals and local community members who are supposed to make sure people aren't being harmed and the trials are pursuing a valid scientific question. Once the design parameters proposed by the lead scientists are set, any number of physicians can raise their hands to enroll patients in the trials.

Over the past decade, an increasing number of cancer studies have come under fire from prominent academics. Perhaps the most scathing critic is Vinay Prasad, now chief

medical and scientific officer at the FDA. Before he was picked for the job in May, he was a UC San Francisco hematologist-oncologist known for skewering what he saw as flawed cancer trials. He did so in a 2020 book called Malignant, research papers and YouTube videos in which he sometimes let expletives fly about “sh-tty” or “absolutely worthless” work. The trial that led to Pluvicto’s approval was among his targets. (An FDA spokesperson said Prasad and other officials were unavailable to comment.)

In one 2024 video, dressed in a faded tie-dyed T-shirt, he deemed oncology “deeply broken,” with doctors and researchers captured by the manufacturers. “It is really the love of money that is driving this whole field,” he said. “What’s best for patients is so far on the back burner that people have forgotten it entirely.” When the textbooks are written years from now, he added, many oncology trials “are going to look so unethical.”

One basic way many trials manipulate results, Prasad and other critics say, is through the choice of treatment given to patients in the control group. Trials are often designed to give patients the “least possible treatment that will not bring an outcry,” says Bishal Gyawali, an oncologist at Queen’s University in Canada.

“The companies will do everything they can to make their drugs look better,” agrees Tannock, the University of Toronto professor.

In some cases, patients in the control group who’ve already failed one type of therapy are switched to another similar type that is also unlikely to work. Prasad and colleagues found in one 2019 paper that 16 of 96 cancer drugs approved from 2013 to mid-2018 were based on trials with control groups that either gave inferior drugs or excluded some proven options. For patients, it means their care might be worse than if they hadn’t signed up for a trial.

In other instances, patients are denied chemotherapy. This was one of Prasad’s objections to the key Pluvicto trial. In a paper with researchers from Switzerland and Texas, he wrote that the clinical investigators had concocted “bizarre rationales” to justify giving patients in the control group another androgen-inhibiting drug while denying them access to additional chemotherapy. The paper did not dispute that Pluvicto, approved in 2022, was “highly active.”

The trial patients who got Pluvicto lived an average of four months longer than those in the chemo-free control arm. Novartis says the research was designed “to reflect real-world practice and protect patient safety” and the resulting drug “offers patients the chance to delay chemotherapy and live longer without their disease progressing.”

While the chair of the trial’s scientific committee was at Memorial Sloan Kettering, 46 of the 861 patients were enrolled at XCancer in Omaha, according to Nordquist. That’s more than any other site, he says, and more than quadruple the average of other sites, federal records show. “I’m not smart enough to help design these,” Nordquist says of

the concerns raised about the trial. “I run them and I run them well.” Novartis declined to comment on trial enrollment. It bought the small company developing Pluvicto in 2018, after the trial was underway.

Memorial Sloan Kettering oncologist Michael Morris, the trial’s scientific committee chair, wrote in an email that while some studies have inappropriate control arms, this “was just not one of those studies.” He said the trial was designed for the most advanced prostate cancer patients, and most do not get further chemotherapy after one type fails, either by choice or because they are no longer fit to receive it.

The New York hospital is projected to enroll 5,000 patients in clinical trials this year. That’s a 25% decline from 2023, despite increased demand for patients, because highly targeted trials make it harder to identify eligible people, according to Paul Sabbatini, the hospital’s senior vice president for clinical research.

It takes the hospital 150 days on average to open a study, faster than the 175-day average for its peers, he says.

Considering the increased demand, it’s crucial that smaller community centers begin enrolling patients to help fill it, Sabbatini says. Memorial Sloan Kettering is trying to bring them into the fold with a “decentralized” system where those clinics would work in collaboration with the hospital, and under the purview of its review systems.

How best to share the financial incentives involved in those trials is still an open question, he says. Guidelines published by the American Medical Association aren’t legally binding but say compensation should be at “fair market value,” and that the “nature and source of funding” should be disclosed to prospective participants.

Sabbatini says Memorial Sloan Kettering investigators disclose if they have an ownership stake or have received consulting or other payments that might pose conflicts. But when it comes to fees paid to the hospital itself for enrolling patients in studies, disclosure is limited to letting patients know which drug companies are sponsoring the trial, he says.

A similar approach might present ethical risks at a for-profit center, Sabbatini says. “As these trials move into these sites, how is the patient informed of that?” he asks. “How is the patient informed about the financial conflicts of interest or what is driving the offering of this trial? The more transparency the better.”

At XCancer, Nordquist himself pitches patients on clinical trials. New patients get a generous amount of time with him, two to three hours. About 20 minutes is devoted to “dispelling a lot of the myths and misconceptions” about research, a conversation he never skips because “it puts a seed there,” he says, “and then every time they come in, we’re always discussing research so it builds on that seed.” Some 30% of his patients

eventually enroll, higher than the 7.1% trial participation rate among cancer patients nationwide.

A South Dakota native, he originally didn't set out to become a doctor at all. Nordquist graduated with a pharmacy degree from Creighton University in Omaha in 1992, then moved to Oregon, but his new professional life derailed almost as soon as it started.

In December of that year, he took "a quantity of assorted merchandise and prescription drugs" from his employer, according to a 1993 disciplinary action obtained by Bloomberg. His license was suspended for 60 days and he was put on probation for two years, meaning he couldn't act as a "pharmacist in charge." The incident followed him back to Nebraska, where the board of pharmacy filed a reciprocal action against his license there. He went back to medical school at Creighton.

"It's an ugly thing in your past when you're 22 years old," Nordquist says. He calls the episode a "bad judgment" that "has no bearing on XCancer operations or how I treat patients today." He adds he disclosed the sanction while applying to schools and employers.

In the seven years through 2024, Nordquist's companies have received at least $22 million in funding from pharmaceutical companies, federal data show.

Not all of that is profit. Clinical trial payments cover direct costs of administering trials, from the drugs themselves to the items needed to administer them. And then there's the "overhead" – an amount that's tacked on top to cover operating costs. This can also boost a clinic's profit margin. The overhead charge at XCancer is 30% to 35% of the overall budget, according to Nordquist. That's in line with other cancer centers, though Nordquist says one pharmaceutical founder told him his firm's "value is better" because it can enroll patients so efficiently.

A large research staff and custom software for managing trial data is part of the reason. Former employees also point to an atmosphere much like a family company, where Nordquist gets the final say on important decisions, including what trials to open and what treatment regimens to offer. Enrolling patients into trials is a top priority.

Some key decision-makers are personally close to him. Stacy Moore, Nordquist's fiancee, serves as president of the company and vice president of its research operations. For years, Nordquist's brother Tim served as chief operating officer, in charge of finances and human resources. He's now a Lutheran pastor. Nordquist says it is not uncommon to have family members on the staff of a small business and, as for Moore, "our professional conduct is exactly that, professional."

At XCancer, Nordquist says, legal reviews have sometimes been completed in a single day. They might take months at research hospitals. Trials must also be approved by an

independent review board – something that might add months more at a big hospital. Nordquist prefers professional, for-profit review board services. One used by XCancer, WCG, is owned by private equity firms and promotes that it will review studies deemed “minimal risk” to patients in one to two business days.

Each patient who enters XCancer is screened for trial eligibility, which can involve a long list of criteria, some of which are subject to judgment calls. When there’s gray area about whether a patient has failed other therapies that they’ve tried, Nordquist sometimes has leaned on the side of eligibility, according to three former employees, who asked for anonymity to avoid professional consequences. “The checks and balances system is sort of bypassed,” one says. Nordquist denies any focus on enrolling patients quickly. “Our focus is what is best for the patient,” he says. “We follow the protocol 100% without deviation.”

Described in his XCancer medical records as a delightful 71-year-old gentleman, Odorisio first started seeing Nordquist in 2015 and kept his prostate cancer at bay with the traditional methods: surgery, chemotherapy and hormone therapy drugs.

By 2023, though, the cancer had traveled into his bones. He talked with the team at XCancer about Pluvicto. Odorisio knew Nordquist had been involved in Pluvicto’s approval. Ads for the drug are ubiquitous on TV and show middle-aged men driving golf balls, baking bread or laughing with their grandkids. Odorisio was told the patient response was “good,” he recalled. But his prostate-specific antigen levels quadrupled while on Pluvicto and after receiving five of his six doses, he stopped taking it. The XCancer records described a “mixed response.”

There were other drawbacks the ads hadn’t highlighted. Pluvicto uses a radioactive substance to target and destroy cancer cells, so he had to carry a card after treatments warning that he might give off small amounts of radiation. Not only could he not teach his grandkids to ride a bike, as a man in the ads does, he couldn’t be near them for several days after receiving a dose for fear of irradiating them. “I never asked the question ‘what is good?’ until we got pretty far into it,” Odorisio recalled. “I just felt like I made a mistake.”

The FDA in September called one of the recent ads for Pluvicto misleading, noting that only 49% of men saw their tumors shrink or disappear.

Novartis says there is “robust evidence” of the drug’s safety and efficacy and it is “committed to working with the FDA” to ensure the ads comply with the law. Nordquist says no drug is a cure and they all stop working at some point. “Research is the only way to move that forward,” he says.

Next, Odorisio eagerly signed up for two clinical trials, both experimental drugs from AstraZeneca Plc, with several months of chemotherapy in between.

Neither trial worked any better than Pluvicto did, and his PSA numbers soared again. Nordquist says Odorisio had a very resistant cancer and such responses are "unfortunately a reality in aggressive disease." Nordquist says they would've been discussing hospice care if Odorisio hadn't enrolled in the second trial. "He was adamant about trying this trial," Nordquist says.

The cancer kept spreading. Beleaguered by new setbacks, Odorisio said in August he was still fighting. "I'm not at a point where I can say that I've had enough, I've got five grandkids," he said, his voice cracking.

Clinical trials reimburse patients for costs like travel expenses, and he'd acquired a pre-paid debit card with a balance of about $1,600. "I'm not interested in the money," he said. He hoped to use it to buy the XCancer staff lunch sometime. He never got the chance. On Sept. 26, Odorisio died.

Oversight of the clinical trial process essentially relies on self-policing. When it examines a new drug, the FDA requires investigators to report "disclosable conflicts," such as an ownership stake in the pharmaceutical company that is trialing the drug. The compensation they get from enrolling patients is typically reported separately, to the Centers for Medicare & Medicaid Services. It generally only becomes public after a substantial lag, sometimes years. The upshot is that reviewers at the FDA have no real-time visibility into how the climbing per-patient pay rates might have affected the decisions of those conducting the trial.

Neither do patients, unless an institutional review board insists. Review boards, the agency wrote in guidance published in 2023, "have the final responsibility of determining whether subjects should be provided with information regarding the source of funding, funding arrangements or financial interests of parties involved."

Increasingly, drug companies are looking overseas, to lower-cost trial sites in China and eastern Europe. Nordquist says an emissary from the United Arab Emirates even visited his Omaha clinic, curious how they too could play a bigger role in cancer research.

His business model is already expanding beyond Omaha. In exchange for 30% of revenue, Nordquist's team is helping other community cancer clinics with trials; it will even upload data for them. He's signed up clinics in Colorado, Louisiana and Alabama, with plans for many more.

Nordquist views this as public service. Community cancer centers have long struggled, with fewer business lines and lower insurance payouts than those of big hospitals. Many have closed or sold. Distributing the resources for trials across the country means more

access to cancer care, in more places, for more patients. “I don’t see how this could be bad,” he says.

XCancer even launched a website for patients to find open trials and clinics that are offering them. The site recently showed Nordquist’s clinic participating in a dozen trials, backed by several companies. Novartis was listed as a platinum sponsor, in exchange for what Nordquist says is $100,000 a year.

He’s especially excited about a new therapy offered by an Australian startup called Clarity Pharmaceuticals. After Nordquist tested it on three patients, a Clarity press release quoted him as saying “I have not observed PSA responses like this after a single dose of any agent.”

A few months later, when XCancer became the first global site for the therapy’s latest trial, the holidays were fast approaching, and Nordquist promoted it with another photo. For this one, he donned a Santa hat and hopped in a sleigh.