IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel.,
MIKE HUNTER,
ATTORNEY GENERAL OF OKLAHOMA,

Plaintiff,

v.

(1) PURDUE PHARMA L.P.;
(2) PURDUE PHARMA, INC.;
(3) THE PURDUE FREDERICK COMPANY;
(4) TEVA PHARMACEUTICALS USA, INC.;
(5) CEPHALON, INC.;
(6) JOHNSON & JOHNSON;
(7) JANSSEN PHARMACEUTICALS, INC.;
(8) ORTHO-McNEIL-JANSSEN PHARMACEUTICALS, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.;
(9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN PHARMACEUTICALS, INC.;
(10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.;
(11) WATSON LABORATORIES, INC.;
(12) ACTAVIS LLC; and
(13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,

Defendants.

For Judge Balkman's Consideration

Case No. CJ-2017-816
Honorable Thad Balkman

William C. Hetherington
Special Discovery Master

STATE OF OKLAHOMA } S.S.
CLEVELAND COUNTY }

FILED

APR 16 2019

In the office of the
Court Clerk MARILYN WILLIAMS

DEFENDANTS' MOTION TO EXCLUDE THE TESTIMONY OF STATE EXPERT DR. WILLIAM B. McALLISTER

Pursuant to 12 O.S. § 2702 and *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993), Defendants[1] move to exclude the testimony of State expert Dr. William B. McAllister.

[1] "Defendants" includes Defendants Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Watson Laboratories, Inc., Actavis LLC, Actavis Pharma, Inc., Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen, Pharmaceuticals, Inc., N/K/A Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc., N/K/A Janssen Pharmaceuticals, Inc.

I. INTRODUCTION

The State's Expert Witness Disclosures ("Disclosures") state that Dr. McAllister will seek to provide an expert opinion on the following topics:

- The historical relationship between human beings and opiates;
- The impact of the Asian opium trade and the international response thereto;
- The history of the interrelationship between opiate addiction and opiate-related epidemics in foreign countries to those phenomena in the United States; and
- Efforts to abate previous opiate addiction epidemics and to prevent subsequent addiction epidemics

(Exhibit N to Disclosures.) Dr. McAllister's testimony on these topics should be excluded because, as Dr. McAllister confirmed during his deposition, all of his testimony will consist of and be based exclusively on his knowledge of historic opioids and opioid epidemics that are materially different than the current "crisis" allegedly affecting the State of Oklahoma. Indeed, Dr. McAllister confirmed during his deposition that his testimony will consist solely of his opinions as to opioid epidemics in different countries, involving different opioids, during different time periods, with different actors, and under different regulatory systems than those present in Oklahoma's alleged current opioid epidemic—which is the only relevant scenario in this litigation. Simply put, Dr. McAllister's testimony will not be relevant, much less useful, to resolving any of the issues in this action. And whatever minor relevance the State will argue Dr. McAllister's opinions may hold, it is vastly outweighed by the waste of this Court's time that will come from introducing testimony about historical and international events that are materially different from what is relevant in this action.

Worse yet, Dr. McAllister seeks to introduce testimony on how "historical perspective" can "inform the cause" of the opioid epidemic in the State of Oklahoma, and how "historical

precedents" can inform the foreseeability of the opioid epidemic in the State of Oklahoma.[2] Specifically, Dr. McAllister seeks to testify that as of 1996, it was "clear" to pharmaceutical manufacturers in Oklahoma that if they "were able to successfully increase supply of addictive opioid narcotics to any populace on a mass scale, the outcome would be entirely predictable: the populace would become addicted while suppliers would get rich." (Exhibit N to Disclosures.) Dr. McAllister's conclusions as to the purported causes and foreseeability of the current opioid epidemic, however, are nothing more than speculative guess-work based on zero data or analysis, and should be excluded. Indeed, Dr. McAllister expressly conceded that he is not an expert on causation and is not providing an expert opinion on what caused the alleged opioid epidemic in the State of Oklahoma. (McAllister Dep. Tr. at 176:13-177:20.)

While Dr. McAllister is arguably qualified to opine as a historian what took place during *past* opioid epidemics, he simply lacks the knowledge, skill, experience, training, or education required to qualify him as an expert on a *current* opioid epidemic in Oklahoma, much less on its causes or its foreseeability. As Dr. McAllister candidly admits, the current opioid epidemic affecting the State of Oklahoma is "different in several respects" from those which he has studied.[3] And these differences are made worse by the fact that Dr. McAllister also admits that he has "not studied the current situation [in Oklahoma] in any detail."[4] Indeed, contrary to the opinions he seeks to introduce but seemingly aware that he is not qualified provide them, Dr. McAllister admits that he is *not* seeking to provide *any* opinion as to the current opioid epidemic in Oklahoma.

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[2] (McAllister Dep. Tr. at 174:22-175:2; 175:13-16.) The deposition excerpts cited herein are attached as Exhibit 1.

[3] (McAllister Dep. Tr. at 67:24-68:14.)

[4] (McAllister Dep. Tr. at 110:23-111:3.)

(McAllister Dep. Tr. at 177:17-20.) ("**Q**: And you're not making any expert -- you're not giving any expert opinion specifically as to as to the opioid epidemic in Oklahoma are you? **A**: No.")

In sum, Dr. McAllister's purported expert testimony fails to satisfy the basic requirements of 12 O.S. § 2702 and *Daubert*. As a result, Dr. McAllister's testimony should be excluded in its entirety.

II. LEGAL STANDARD

Oklahoma evaluates the admissibility of expert testimony pursuant to the standards established by the United States Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), and its progeny. *Christian v. Gray*, 2003 OK 10, ¶ 14, 65 P.3d 591, 600. The Oklahoma statute governing expert testimony, 12 O.S § 2702, is "identical in substance" to Federal Rule 702, *id.*, 2003 OK 10, ¶ 6, 65 P.3d 591, 597, and provides that:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify in the form of an opinion or otherwise, if (1) [t]he testimony is based on sufficient facts or data; (2) [t]he testimony is the product of reliable principles and methods; and (3) [t]he witness has applied the principles and methods reliably to the facts of the case.

12 O.S. § 2702. These three requirements to admissibility are commonly known as "qualification," "reliability," and "fit." The State, as the party offering the expert testimony, has the burden of proving admissibility by a preponderance of the evidence. *Daubert*, 509 U.S. at 592.

Daubert requires this Court to perform a "screening function" to ensure that Dr. McAllister's testimony is "not only relevant, but reliable." *Id.* at 589, 592. The purpose of the reliability analysis is to "make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Kumho*, 526 U.S. at 152. In order to survive this requirement, the "proposed testimony must be supported by appropriate validation—

i.e., 'good grounds,' based on what is known." *Daubert*, 509 U.S. at 590. Thus, an expert's opinion must "rest on a reliable foundation." *Id.* at 662. When the expert opinion is inadequately supported by reliable data, methodology, or studies, "[a] court may conclude that there is simply too great an analytical gap between the data and the opinion proffered," and thus may exclude the expert testimony. *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997).

In performing its gatekeeping role, the trial court also must determine whether the proffered expert testimony is relevant, that is, whether it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." 12 O.S. § 2402; *Ross v. Otis Elevator*, 1975 OK 105, 539 P.2d 731, 733-34. Evidence of collateral or other facts which do not affect a reasonable presumption or inference as to the principle fact in dispute is irrelevant and inadmissible. *Id.* Additionally, relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice and confusion of the issues, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence. 12 O.S. § 2403; *see Madill Bank & Trust Co. v. Hermann*, 738 P.2d 567, 571 (Okla. Civ. App. 1987).

The testimony of Dr. McAllister fails the basic requirements of 12 O.S. § 2702 and *Daubert*.

III. ARGUMENT

A. Dr. McAllister's Opinions On Opioids and Opioid Epidemics Other Than The Opioids and Current Opioid Epidemic In Oklahoma Should Be Excluded.

All of the State's claims in this action pertain to the purported effects in the *State of Oklahoma* of the alleged marketing activities of pharmaceutical manufacturers with regards to FDA-regulated prescription opioid medications in *the State of Oklahoma*. Dr. McAllister's opinions on opioid epidemics in other countries, involving different opioids, during different times,

with different actors, and under different regulatory systems than those present in Oklahoma, are simply not relevant or helpful in resolving any factual or legal issue in this case. Further, whatever imagined minor relevance the State will argue exists is vastly outweighed by the near-certainty that introduction of testimony will waste this Court's time. Accordingly, it should be excluded.

Dr. McAllister's testimony related to past opioid epidemics, in China and elsewhere, is not relevant because as he himself admits, these past epidemics are "different in several respects" (McAllister Dep. Tr. at 67:24-68:14) compared to the current opioid epidemic in the State of Oklahoma:

> **Q:** But I'm talking about Oklahoma.
>
> **A:** No.
>
> **Q:** Do you know how, then, the opioid epidemic in China, which you recently discussed, is different from the opioid epidemic that's presently taking place in Oklahoma?
>
> **A:** How is it different?
>
> **Q:** Yeah.
>
> **A:** Well, the particular drug in question is a different form of morphine; it's smoking opium. So that was the -- that was the major problem. However, by the turn of the 20th century, there was also both morphine and heroin being imported into China, as well. That was a smaller part of the problem then. But the -- the main difference would be the – the epidemic had to do with smoking opium."

(McAllister Dep. Tr. at 65:17-66:6.)

> **Q:** Before the Communist Party took over in 1949, was there regulation of opium products in China?
>
> **A:** Well, technically and theoretically, yes, but the civil war really prevented those from being implemented in a -- in a significant way.
>
> **Q:** Are there regulations in place in Oklahoma, in the United States, with regard to the prescribing of prescription opioids?
>
> **A:** Yes.

Q: That's a difference between the two, right?

A: Well, the regulations were there. The implementation was an issue in China.

Q: But the -- but there is -- there are regulations being implemented in the United States, presently, and in Oklahoma, governing the --

A: Yes.

Q: -- distribution of prescription opioids --

A: Yes.

(McAllister Dep. Tr. at 66:13-67:5.)

Q: What other differences? Let me ask this question: Have you -- have you considered the differences between the opioid crisis, presently in the United States and Oklahoma, and China?

A: Yes.

Q: Okay. So what are the differences, besides the ones we've discussed?

A: Well, the world situation is different in several respects. There was a lot of instability in the 1920s and 1930s. Also, the international control regime sort of comes into its modern form in 1933. So there were some differences before then, in what was licit and what was illicit and -- and what was expected, what was the norm, before 1933. What I tend to focus on more is the similarities.

Q: I'm not talking about 1933, Doctor. I'm talking about now, today.

A: Uh-huh.

(McAllister Dep. Tr. at 67:24-68:17.)

Q: The comparison between today and the opium epidemic in China. There was also -- there was also the difference that the government -- the -- presently, the government limits the number of prescription opioids available, right?

MR. PATE: Object to form.

A: I'm sorry, ask again. The...

Q: Another difference between the opioid epidemic in China that you've discussed, pre-1949, and the opioid issues being faced currently in the United States and in

Oklahoma, is that the government presently limits the number of prescription opioids available, right?

A: I -- I understand that to be the case, yes.

Q: The DEA sets the quota every year for how many opioids can be produced, correct?

MR. PATE: Object to form.

A: Correct.

Q: And that did not take place in China pre-1949?

MR. PATE: Object to form.

A: That's correct.

(McAllister Dep. Tr. at 68:18-69:15.)

Q: Another difference is: You have insurers which may or may not pay for opioids in the United States today, but there were no insurers paying for opioids in China prior to 1949, correct?

A: That's probably true, yes, I'm -- yes.

(McAllister Dep. Tr. at 69:16-20.)

Q: "Another difference is: You have medically-assisted treatment here in the United State presently, but you didn't have that pre-1949 in China, correct?

MR. PATE: Object to form.

A: Oh, there were -- there were treatment programs. Their success is up for some debate, but there were certainly attempts to -- to have treatment for people who were addicted.

Q: Was Suboxone availa- -- do you know what Suboxone is?

* * *

A: No.

* * *

A: I think those all post-date that period.

Q: Did they have methadone?

A: Methado- -- no, methadone is a World War II invention.

(McAllister Dep. Tr. at 69:21-70:16.)

The expert testimony of historians has been held admissible when, among other things, it is relevant to the history of an issue in the litigation. *See Burton v. Am. Cyanamid*, No. 07-CV-0303, 2018 WL 3954858, at *11 (E.D. Wis. Aug. 16, 2018) (holding historian's expert testimony admissible where historian testified to the market share history of various paint manufacturers *in Wisconsin*, where issue was manufacturers' liability regarding the presence of harmful paint used *in Wisconsin*). Examples of history relevant to this case would be, for example, the history of the opioid epidemic in Oklahoma, or the history of pharmaceutical manufacturers' opioid-related marketing in Oklahoma. But this is not the kind of history Dr. McAllister seeks to introduce.

Instead, Dr. McAllister seeks to opine on the history of opioid epidemics in different countries, involving different opioids, during different times, with different actors, and under different regulatory systems than those present in Oklahoma. This history is simply not relevant nor useful in resolving any issue as to the State of Oklahoma. Where, as here, the history sought to be introduced is completely removed from any issue in the litigation, courts have routinely held that it is inadmissible. For example in *Linde v. Arab Bank, PLC*, a case brought by victims of terrorist attacks in Israel against a Jordanian bank for allegedly transferring funds to a terrorist organization, the court held that expert testimony relating to the history of the Israeli-Arab conflict was not relevant:

> [E]ven if it could be said that some statements in some of the reports reference matters of marginal relevance to the discrete issues for trial in this case, ***the reports are so far afield from the specific allegations and statutory elements at issue that there is an appreciable risk of prejudice, jury confusion, and misleading the jury.*** The ***trial, anticipated to be lengthy, cannot be burdened with extraneous issues such as . . . the lengthy history of social, political, economic, and diplomatic factors relating to a conflict that goes well beyond the issues in this case.***

920 F. Supp. 2d 282, 286 (E.D.N.Y. 2011) (emphasis added.) Similarly, in *Cook v. Rockwell International Corp.* the federal government offered a historian's expert testimony to justify an ongoing nuisance that was allegedly important to national security. 580 F. Supp. 2d 1071 (D. Colo. 2006). The *Cook* court excluded the historian's expert testimony, finding that:

> [The] proffered testimony regarding the "dawn of the nuclear age" in World War II, the origins of the Cold War armament race and related Soviet espionage, ***has little to no probative value here.*** Whatever probative value this testimony might have in providing a background to the federal government's decision to construct and operate [the entity responsible for the nuisance] is ***substantially outweighed by the danger of unfair prejudice and confusion of the issues, and [of] needlessly wast[ing] trial time.***

Id. at 1167 (emphasis added). This Court should hold the same. An already lengthy trial should not be protracted one day for an unnecessary detour into the nineteenth century Chinese opium trade.

B. Dr. McAllister's Opinions On The Current Opioid Epidemic In Oklahoma Should Be Excluded.

An expert may be qualified to testify "by knowledge, skill, experience, training, or education." *Gray*, 2003 OK 10, 65 P.3d 591, 597. Here, Dr. McAllister is simply not qualified to provide any opinion about the current opioid crisis in Oklahoma. Dr. McAllister is a historian of foreign policy—not an epidemiologist. (McAllister Dep. Tr. at 177:17-20.) As explained above, Dr. McAllister admits that the current opioid epidemic in Oklahoma is unlike those he has studied. Further, Dr. McAllister also admits that he has failed to conduct any research to supplement this deficiency. Aware of his inability to provide an expert opinion as to Oklahoma, when asked during his deposition if he intended to "give an opinion [] about the present opioid crisis in the State of Oklahoma," Dr. McAllister answered "No." (McAllister Dep. Tr. at 122:20-25.)

Yet, Dr. McAllister seeks to introduce testimony that projects "lessons learned" from opioids and opioid epidemics materially different and irrelevant to those at issue in this action, and

subsequently attempts to apply them to a complex modern public health phenomenon—the alleged opioid epidemic currently affecting the State of Oklahoma. Dr. McAllister intends to opine on how "historical perspective" can "inform the cause" of the opioid epidemic in the State of Oklahoma, and how "historical precedents" can inform the foreseeability of the opioid epidemic in the State of Oklahoma. (McAllister Dep. Tr. at 174:22-175:2; 175:13-16.) Specifically, Dr. McAllister seeks to opine that it was "clear" to pharmaceutical manufacturers in Oklahoma that if they "were able to successfully increase supply of addictive opioid narcotics to any populace on a mass scale, the outcome would be entirely predictable: the populace would become addicted while suppliers would get rich." (Exhibit N to Disclosures.) But Dr. McAllister's experience with ***past*** opioid epidemics—in different countries, involving different opioids, during different times, with different actors, and under different regulatory systems—does ***not*** qualify him as an expert on the ***current*** opioid epidemic in Oklahoma, much less on its causes or its foreseeability. Dr. McAllister's testimony as to these issues is unreliable and should be excluded.

As explained in more detail in Section II.A, Dr. McAllister himself admits that the current opioid epidemic in Oklahoma is unlike those he has studied, and is in fact "different in several respects." (McAllister Dep. Tr. at 67:24-68:14); *see* Section II.A (collecting deposition testimony from Dr. McAllister admitting to various material differences). The differences between the current opioid epidemic in Oklahoma and those Dr. McAllister has studied are made worse by the fact that Dr. McAllister has taken no steps to research or educate himself on the current opioid crisis in Oklahoma. Indeed, Dr. McAllister concedes at various times that he has "not studied the current situation [in Oklahoma] in any detail" (McAllister Dep. Tr. at 110:23-111:3), and that, as a historian, he is not qualified to provide an opinion as to something so "recent" as the current opioid epidemic in Oklahoma:

Q: Have you studied the opioid crisis in Oklahoma?

A: I have seen some -- the news reports.

Q: Beyond news reports, have you studied the opioid crisis in Oklahoma?

A: Of recent vintage, no.

Q: When you say "of recent vintage," how recent?

A: Well, as a historian, it's necessary to get a look at documentation, so, in my case, that's typically 30 years back. So anything within, you know, 20 years or closer to the present, it's often difficult for historians to get enough documentation to use our professional skills to come up with an opinion.

Q: So you haven't really looked at anything since the '90s?

A: Let's see...

MR. PATE: Object to form.

A: I have looked at some of the public documentation of the international organizations for the 2000s.

Q: But I'm talking about Oklahoma.

A: No.

(McAllister Dep. Tr. at 64:22-65:18.)

Q: When, in the United States, were -- were prescriptions required for opi -- for opiates?

A: Nationally, I assume that would be the Harrison Narcotics Act. That would be 1914, I -- however, certain jurisdictions would have done it sooner. Certain states probably would have required it sooner, so it's going to vary.

Q: Do you know if Okla- -- Oklahoma required it sooner?

A: I do -- I have not looked for that, not researched that.

(McAllister Dep. Tr. at 85:10-20.)

Q: Are you aware of how doctors are trained at -- in residency programs in Oklahoma, about the use of Schedule II opioids?

MR. PATE: Object to form.

A: I am not aware -- because I'm a historian, I'm not aware of what is being done currently . . .

(McAllister Dep. Tr. at 88:21-89:1.)

Q: Okay. In that sentence that we just read, you say, "The conservative stance was reflected and reinforced by the regulatory and legislative measures taken by the United States and the international community."

A: Uh-huh.

Q: Are you aware of -- that conservative stance, whether that was taken in Oklahoma?

A: No, I did not study state-level legislation.

Q: So you – you're not familiar with any legislative efforts taken in the State of Oklahoma related to the -- related to prescription opioids?

MR. PATE: Object to form.

A: No . . .

(McAllister Dep. Tr. at 93:14-94:1.)

Q: But with regard to Oklahoma specifically, you have not looked at legislative efforts post-1990?

A: No.

Q: And you're not expressing any opinion on the legislative efforts, or lack thereof, taken by Oklahoma since 1990?

A: No.

(McAllister Dep. Tr. at 94:15-21.)

To Defendants' knowledge, no court has ever held that an individual with no relevant education or experience—as Dr. McAllister admits is true with regards to his knowledge of the current opioid epidemic in Oklahoma—may provide an expert opinion on said topic. As such, Dr. McAllister's testimony should be excluded.

IV. CONCLUSION

For the multiple, independent reasons described above, Defendants respectfully request that this Court exclude the testimony of Dr. McAllister in its entirety.

Respectfully submitted,

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I hereby certify that a true and correct copy of the foregoing was emailed this 16th day of April, 2019, to the following:

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S504463

EXHIBIT 1

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE HUNTER, ATTORNEY GENERAL OF OKLAHOMA, Plaintiff,	)	
-vs-	)	No. CJ-2017-816
PURDUE PHARMA, L.P.; et al., Defendants.	)	

* * * * *

VIDEOTAPED DEPOSITION OF WILLIAM B. MCALLISTER, Ph.D.

TAKEN ON BEHALF OF THE DEFENDANTS

IN OKLAHOMA CITY, OKLAHOMA

ON MARCH 19, 2019

COMMENCING AT 9:09 A.M.

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REPORTED BY: BETH A. McGINLEY, CSR, RPR

time is 10:21.

(Recess was had from 10:21 a.m. to 10:32 a.m.)

THE VIDEOGRAPHER: We're back on the record. The time is 10:32. Beginning Disk 2.

Q (By Mr. Bartle) Doctor, before we went on break, we were talking about -- you still have Exhibit N in front of you?

A I'm --

Q I'm sorry, Exhibit 3?

A Yes, yes.

Q This is your disclosure?

A Yes.

Q Was there any one factor that was 100 percent determinative in creating the Chinese opioid epidemic?

A One factor... I don't know how one would determine that. The preponderant factor was a massive influx of smoking opium into the country.

Q And that was unregulated, right?

A I -- I'm sorry, say --

Q It was unregulated?

A Yes.

Q And can you explain how the Chinese opioid epidemic was brought under control in the 1950s?

A The Chinese went through, essentially, three different campaigns. There's an article on this, which I

haven't read for a while, so the details escape me a little bit, but the bottom line is: They first tried a campaign to sort of just hector people into changing, and that really didn't work, so then they -- then the next campaign was very focused on the cities and very focused on dealers and they threw a lot of people in jail and they arrested a lot of people and they sort of made it clear to the populous that it was no longer going to be tolerated. And that worked for the cities -- that took a couple of years of punitive actions in the cities.

And then it took them about a decade after that to slowly work through the countryside, where a lot of opium was being grown, and to, sort of, go province by province and suppress production, agricultural production, to the point where they, sort of, worked it out of the system.

Q And that was the -- the communist --

A Yes.

Q -- government did that, right?

A Yes.

Q How is the Chinese opioid epidemic similar to the problem -- well, let me ask this question first: Have you studied the opioid crisis in Oklahoma?

A I have seen some -- the news reports.

Q Beyond news reports, have you studied the opioid

crisis in Oklahoma?

A Of recent vintage, no.

Q When you say "of recent vintage," how recent?

A Well, as a historian, it's necessary to get a look at documentation, so, in my case, that's typically 30 years back. So anything within, you know, 20 years or closer to the present, it's often difficult for historians to get enough documentation to use our professional skills to come up with an opinion.

Q So you haven't really looked at anything since the '90s?

A Let's see...

MR. PATE: Object to form.

A I have looked at some of the public documentation of the international organizations for the 2000s.

Q (By Mr. Bartle) But I'm talking about Oklahoma.

A No.

Q Do you know how, then, the opioid epidemic in China, which you recently discussed, is different from the opioid epidemic that's presently taking place in Oklahoma?

A How is it different?

Q Yeah.

A Well, the particular drug in question is a different form of morphine; it's smoking opium. So that

was the -- that was the major problem.

However, by the turn of the 20th century, there was also both morphine and heroin being imported into China, as well. That was a smaller part of the problem then. But the -- the main difference would be the -- the epidemic had to do with smoking opium.

Q That's the main difference between what took -- took place in China in -- in pre-1950, and what's taking place in Oklahoma today?

A Yes. The main similarity being that the -- sort of the morphine base, that is sort of the essential product, was addicting people.

Q Before the Communist Party took over in 1949, was there regulation of opium products in China?

A Well, technically and theoretically, yes, but the civil war really prevented those from being implemented in a -- in a significant way.

Q Are there regulations in place in Oklahoma, in the United States, with regard to the prescribing of prescription opioids?

A Yes.

Q That's a difference between the two, right?

A Well, the regulations were there. The implementation was an issue in China.

Q But the -- but there is -- there are regulations

being implemented in the United States, presently, and in Oklahoma, governing the --

A Yes.

Q -- distribution of prescription opioids --

A Yes.

Q -- right?

And I'm not talking about heroin or illicit fentanyl.

A We're just talking about the licit side of the --

Q I'm talking the licit, as opposed to the illicit.

A Yes, correct.

Q So we've got -- the difference, you've mentioned, was the smoking opium, right?

A Uh-huh.

Q Obviously, we have regulations being implemented in the United States, right --

A Uh-huh.

MR. PATE: Object to form.

Q (By Mr. Bartle) -- as opposed to China?

MR. PATE: Object to form, misstates testimony.

A (Moved head up and down.)

Q (By Mr. Bartle) What other differences? Let me ask this question: Have you -- have you considered the

differences between the opioid crisis, presently in the United States and Oklahoma, and China?

A Yes.

Q Okay. So what are the differences, besides the ones we've discussed?

A Well, the world situation is different in several respects. There was a lot of instability in the 1920s and 1930s. Also, the international control regime sort of comes into its modern form in 1933. So there were some differences before then, in what was licit and what was illicit and -- and what was expected, what was the norm, before 1933.

What I tend to focus on more is the similarities.

Q I'm not talking about 1933, Doctor. I'm talking about now, today.

A Uh-huh.

Q The comparison between today and the opium epidemic in China.

There was also -- there was also the difference that the government -- the -- presently, the government limits the number of prescription opioids available, right?

MR. PATE: Object to form.

A I'm sorry, ask again. The...

Q (By Mr. Bartle) Another difference between the opioid epidemic in China that you've discussed, pre-1949, and the opioid issues being faced currently in the United States and in Oklahoma, is that the government presently limits the number of prescription opioids available, right?

A I -- I understand that to be the case, yes.

Q The DEA sets the quota every year for how many opioids can be produced, correct?

MR. PATE: Object to form.

A Correct.

Q (By Mr. Bartle) And that did not take place in China pre-1949?

MR. PATE: Object to form.

A That's correct.

Q (By Mr. Bartle) Another difference is: You have insurers which may or may not pay for opioids in the United States today, but there were no insurers paying for opioids in China prior to 1949, correct?

A That's probably true, yes, I'm -- yes.

Q Another difference is: You have medically-assisted treatment here in the United States presently, but you didn't have that pre-1949 in China, correct?

MR. PATE: Object to form.

A Oh, there were -- there were treatment programs. Their success is up for some debate, but there were certainly attempts to -- to have treatment for people who were addicted.

Q (By Mr. Bartle) Was Suboxone availa- -- do you know what Suboxone is?

A The boxer rebellion?

Q Suboxone.

A Oh, Sub- --

Q S-U-B --

A No.

Q -- O-X-O-N-E?

A I think those all post-date that period.

Q Did they have methadone?

A Methado- -- no, methadone is a World War II invention.

Q Can you think of any other differences?

A Hang on just a second, let me get that.

Well, I could list a number of differences in the particulars, but, once again, in -- in general, the phenomenon that I see here is an addicting substance that, once it gets loose in a population, causes all sorts of problems.

Q Do you know what a Schedule II substance is?

A Schedules de- -- matter -- it depends on which

country you're talking about and whether you're talking about the international treaties or not, because the schedules are -- the -- different.

So I'm not particularly familiar with Schedule II in the United States, if that's what you're talking about. I know what Schedule II means in the treaties, but that's different, so...

Q Got it. And that was -- my -- my question was unclear.

Are you aware of how the DEA defines Schedule II?

A I haven't looked at that recently.

Q When was the last time you looked at it?

A Probably when I was writing the book, maybe 20 years ago.

Q Okay. Let's move on to the next paragraph, which begins, "China became the poster child for the negative effects that opium products can have on a civilized society and the international community began taking steps to prevent a recurrence of the Chinese debacle in other countries."

A Uh-huh.

Q Do you see that?

A Uh-huh.

Q Who italicized "the" before poster child?

specifically, so I don't know.

Q If you go down, Doctor, in that paragraph, the one that begins, "China became the poster child" --

A Uh-huh.

Q In the last sentence, you say, "The United States was among the countries that fell victim to an iatrogenic addiction epidemic brought on by a boom in medicines that were prescribed by physicians throughout the country for a wide range of maladies." Do you see that?

A Yes.

Q Can you define "iatrogenic," I-A-T-R-O-G-E-N-I-C?

A Iatrogenic is generally taken to mean initiated or caused by someone in the medical profession.

Q And what are you referring to when you say here, "The United States was among the countries that fell victim to an ia- -- to an iatrogenic addiction epidemic"?

A So when morphine and heroin become -- they begin to become commonly used -- relatively commonly used by physicians in western countries in the 1870s. And they begin to notice problems with the use of these drugs by the 1880s, or certainly into the 1890s. And then the doctors, themselves, begin to adjust medical training and they write in their journals about the dangers and

governments begin to get involved, as well.

So part of the -- part of the historical element here is that there's no requirement to have pre- -- prescriptions in most countries until sometime in the early 20th century. Some countries don't require it until after World War I. So -- so in order to have a licit system, you have to have several elements that we're used to now, that didn't exist as late as 1910 or 1920, in countries.

Q When, in the United States, were -- were prescriptions required for opi- -- for opiates?

A Nationally, I assume that would be the Harrison Narcotics Act. That would be 1914, I -- however, certain jurisdictions would have done it sooner. Certain states probably would have required it sooner, so it's going to vary.

Q Do you know if Okla- -- Oklahoma required it sooner?

A I do -- I have not looked for that, not researched that.

Q Okay. Do you know when Oklahoma became a state?

A 1907.

Q I'm testing you, Doctor, because I know you --

A Hey, I'm --

Q -- were born in Oklahoma.

A -- I'm certified to teach Oklahoma history; if I don't know that, I'm in trouble.

Q Let's move to the next -- so you -- so when you're -- what you're referring to here, in this paragra- -- in this sentence that begins, "The United States was among the countries," you're talking about late 19th or early 20th centuries?

A Yes. Yes.

Q And then you write -- the next paragraph that begins, "The -- The supply and variety of drugs increased"?

A Uh-huh.

Q Hyphen, "most notably, the medicinal opioids that led to an iatrogenic addiction in the United States and other western countries," closed hyphen.

A Uh-huh.

Q "Societies began to adopt a highly-conservative approach to the use of opium-derived products and undertook actions to suppress problematic consumption."

A Yes.

Q What do you mean by "highly-conservative approach"?

A This is what we're calling, for the purposes of this case, narcotic conservatism, that these drugs have an important value in medical practice, but, because they're

so dangerously-addicting and all the problems that come from that, they should be reserved for very significant cases of pain, and that if there are appropriate ways to treat patient pain, without having to resort to these drugs, that should be the norm, and there should also be a real attempt to discover and treat the underlying causes of the pain, rather than just ameliorate the pain.

Q And you're not a medical doctor, right?

A No.

Q You've never treated anybody for pain?

A No.

Q And you would agree with me that the -- the appropriate determination as to what a particular patient needs is a decision between that doctor, that -- and that patient, right?

A Yes. Let me just say, though, that in terms of the doctor, the doctor has certain professional, ethical, you know, responsibilities that need to -- that -- the decision is partly dependent on the doctor fulfilling their professional responsibilities.

Q Certainly.

A Okay.

Q Certainly. No, I would agree with that.

A Sure.

Q And you would agree with me that a -- if a

doctor doesn't fulfill his or her professional responsibilities, they're doing a disservice and potentially harming their patient?

MR. PATE: Object to form, outside his expert disclosure, but go ahead.

A Yes, but I would also say that doctors are dependent on the information they receive in order to make those determinations.

Q (By Mr. Bartle) And we've already talked, earlier: You're not aware of what "Schedule II" means in the United States, right?

A I have not read it recently, no.

Q And are you familiar with what -- how doctors are trained at, for example, OU Medical School, about the use of Schedule II opioids?

MR. PATE: Object to form.

A No.

Q (By Mr. Bartle) What about OSU Medical School?

MR. PATE: Object to form.

A No.

Q (By Mr. Bartle) Are you aware of how doctors are trained at -- in residency programs in Oklahoma, about the use of Schedule II opioids?

MR. PATE: Object to form.

A I am not aware -- because I'm a historian, I'm

not aware of what is being done currently. I have some sense of how -- in a general sense, of how they trained doctors in the past.

Q (By Mr. Bartle) And when you say "the past," what's the -- what's the most recent date for the past?

A Well, the general protocols were in place by the 1920s.

Q So you're saying the training of doctors at medical schools in Oklahoma is the same as it was in the 1920s?

MR. PATE: Object to form, misstates his testimony.

A No.

Q (By Mr. Bartle) What are you saying?

A What I'm saying is that the general attitude towards the appropriateness of prescribing narcotics -- "opioids" is what we're using for this court case -- the -- the general conservative attitude was in place by the 1920s.

Q And that's what you discussed earlier, where there was a recognition that, while these medicines could provide significant medical benefits to patients, there was also a potential detrimental effect to their use, correct?

A Uh-huh.

Q Okay.

A So there's a risk/reward ratio, but the -- but the approach was heavy on emphasizing the risk, so that they should be conservatively administered.

Q Got it. And then the next sentence of that paragraph, which leads on to the following page: "The development of this prevailing conservative stance on narcotics use was reflected in and reinforced by the regulatory and legislative measures taken by the United States and the international community." Do you see that?

A Uh-huh. Yes.

Q Did I read that right?

A Yes.

Q Is that what you were talking about in your last answer, in the 19 -- the structures in the 1920s?

A Yes. The United States is an important actor in -- in -- for fomenting the international treaties.

Q But I'm talking about specifically in the United States --

A Yeah, so --

Q -- the United States.

A Okay. So it's -- it's two sides of the same coin: The United States passes domestic legislation, but then they realize that needs to be complemented by international legislation, and then sometimes when you get

Q And how would you know that pharmaceutical companies are in favor of that?

A Because if you look in the archival documents, the national authorities who show up in Geneva, for example, to negotiate these treaties, you can see, in the records, significant communications with their domestic pharmaceutical industry before they go to the international meeting, so they -- they know what their constituents want. They don't always give it to them, but they know what they want, so...

Q And what pharmaceutical companies are you talking about there?

A Well, Buyer (phonetic), BASF, Hoffmann-La Roche. The -- the -- the -- the names of the companies change over time. I -- you know, it would be possible to sort of look at the -- the companies, the major pharmaceutical companies that exist today, and go back in time and see how their names and corporate structures have changed over time.

Q But you didn't do that to prepare for your expert testimony today?

A I have not done that today, no.

Q And you haven't done it to prepare your expert opinion as set forth in your disclosure, right?

A Correct.

Q And you're not here to testify as to that, correct?

A I'm sorry, say --

Q You're not -- you're not here to testify as to the specific manufacturers who may or may not have been involved in those efforts?

A In the efforts to help shape the treaties?

Q Uh-huh.

A No. I could, but I -- I just don't have those specifics in front of me.

Q But that's not an expert opinion that you were asked to give in this case, correct?

A Correct. That's correct.

Q Okay. In that sentence that we just read, you say, "The conservative stance was reflected and reinforced by the regulatory and legislative measures taken by the United States and the international community."

A Uh-huh.

Q Are you aware of -- that conservative stance, whether that was taken in Oklahoma?

A No, I did not study state-level legislation.

Q So you -- you're not familiar with any legislative efforts taken in the State of Oklahoma related to the -- related to prescription opioids?

MR. PATE: Object to form.

A No, but what I will say is that when the Harrison Narcotics Act comes into -- is -- is law, that the State would have conformed to that.

Q (By Mr. Bartle) What about recent efforts by the State of Oklahoma in connection with the regulation of prescription opioids?

MR. PATE: Object to form.

A If it's recent, that's outside my area of competence as a historian, so...

Q (By Mr. Bartle) Yeah, and "recent," we're talking post-1990?

A Generally speaking, yes, but some records can be accessed publicly since 1990. So, for example, the board report that we talked about earlier.

Q But with regard to Oklahoma specifically, you have not looked at legislative efforts post-1990?

A No.

Q And you're not expressing any opinion on the legislative efforts, or lack thereof, taken by Oklahoma since 1990?

A No.

Q Let's move on to the next par- -- paragraph, Doctor.

A Uh-huh.

Q You say that, "Knowing that demand for opioid --

opiate products would always be present and lacking adequate tools to treat addicts with consistent success, the international community focused on limiting the supply of these drugs." Do you see that?

A Yes.

Q What did you mean by, "Knowing that demand for opiate products would always be present"?

A Well, there's a general understanding that these drugs have a medicinal use that's appropriate.

Q What about illicit? Does the demand for opiate products include the demand for illicit drugs?

A Well, let me... There was an awareness -- once the licit/illicit distinction is clear, there was an awareness that there would always be the possibility that there would be non-approved, what we would call illicit use, of these drugs.

Q But before the distinction between illicit and licit opiates -- opioids, for example -- people have been using opioids since, I think you said, the -- the dawn of time; is that right?

A Yeah, as far as we can tell, yes. In some way or another, yes.

Q It's not new?

A No. Opium is not new. What we're talking about here is a form of -- of the drug that comes out of opium,

is both fueled by illicit trafficking, but, also, by misuse of licit drugs. It's possible to have both at the same time.

Q (By Mr. Bartle) It's also possible to have -- it's also possible to have -- that each occurred, took place, or was fomented separately, right? Let me rephrase it.

It's possible that you could be -- you could get exposed to illicit heroin and remain addicted to illicit -- illicit heroin, and never have exposure to a prescribed opioid, correct?

A Yes.

Q And the same is true with regard to prescription opioids?

A Correct.

Q Okay.

A Yeah.

Q They don't necessarily -- they aren't necessarily correlated?

A Not necessarily.

Q Correct. And you're aware that the DEA sets quotas for prescription opioids medicines that can be produced in the United States, right?

A Yes.

Q And when you're talking, in your disclosure,

about the straightforward axiom: "Therefore, the supply must be controlled," the DEA, in this case, determines the supply of prescription opioids in the United States; isn't that right?

A Yes, in conjunction with communication with other federal agencies and, also, with the International Narcotics Control Board and the Commission on Narcotic Drugs. They don't just pull a number out of the air, you know, they sort of -- they -- they consult.

Q Sure. But it's the DEA who determines -- they issue a number --

A They would be the primary agency, if that's what you're asking, yes.

Q But they're also the issuing agency for the quota, correct --

A Yes.

Q -- in the United States?

A (Moved head up and down).

Q So if they say it's X, pharmaceutical manufacturers can't produce more than X without violating the law, right?

A Correct.

Q Right. If they raise the quota, then pharmaceutical manufacturers can manufacture up to the quota, correct?

A As far as I understand. And let me say, once again: I have not studied the current situation in any detail, whatsoever, but that's my general understanding.

Q And when you say "current situation," what do you mean?

A Well, once again, in the last 20 to 30 years. These kinds of arrangements were in place before then.

Q But you haven't studied the -- the present situation?

A No.

Q And you're aware that the prescription opioids we're talking about today are all FDA-approved, correct?

A I assume that to be the case.

Q But you're not an expert on that --

A No.

Q -- opinion?

A No.

Q And you're not -- have you ever reviewed an opi-- a label of a Schedule II opioid?

A Ever reviewed a label?

Q Yeah.

A No.

Q Or any opioid -- any prescription opioid in the United States?

A What do you mean by "reviewed a label"?

Q Well, have you looked at the label on a prescription opioid?

A No.

Q Are you aware that the FDA requires labels to be issued with -- with opioids?

A Yes.

Q Okay. And those labels have to contain certain warnings?

A Yes.

Q Okay. And isn't it true that the DEA could raise quotas on prescription opioids in the United States as a result of its determination that those opioids are medically necessary?

MR. PATE: Object to form, calls for speculation.

A They might have raised levels for other reasons. One would be manufacture for export for other countries. I -- I really can't say what goes into their determinations, though, but it's not necessarily just a domestic calculation. That's -- that's what I'll say.

Q (By Mr. Bartle) You say that "the increased opioid supply dramatically increases the risk of addiction." How much does it increase the risk of addiction?

A How much --

Q Why did you pick as of 1996?
A Well, I think it -- that would be true -- I don't recall why I picked 1996, specifically.
Q Are you aware of anything that happened in 1996 that would -- would have caused you to put 1996 on there?
A I cannot recall.
Q Okay. Did your lawyer tell you to put 1996 in there?
MR. PATE: Object to form.
A I don't recall.
Q (By Mr. Bartle) But 1996 is -- is not a particularly significant date for you, in connection with how to analyze an opioid crisis, correct?
MR. PATE: Object to form, vague.
A It may have been. I -- I just don't recall.
Q (By Mr. Bartle) Okay. Do you recall ever studying anything in the United States related to 1996?
MR. PATE: Object to form.
A Not specifically.
Q (By Mr. Bartle) And I think you testified, earlier, you're not here to give an opinion upon -- about the present opioid crisis in the State of Oklahoma, are you?
MR. PATE: Object to form.
A No.

to deploy in their personal capacity, and we are allowed to do that. So I think they have a pretty standard answer they give.

Q Doctor, I want to go back to the first part of Exhibit 3.

A Oh, that's this one? Yeah, right. Okay.

Q You write, in the fourth bullet, under Paragraph A, that one of the things you're testifying about is "efforts to abate previous opiate addiction epidemics and to prevent subsequent epidemics"?

A Uh-huh.

Q Are you an expert on the abatement of opioid epidemics?

A Not in the particular, but, in the general, I'm aware of the sort of attempts and methodologies that have -- that have been tried over time.

Q Okay. And you're not providing any expert opinion today about what would be necessary to abate the opioid crisis in Oklahoma today, will -- are you?

A No.

Q Are you offering any opinion about whether or not there is an oversupply of opioids in Oklahoma today?

A No.

Q How about in the 2000s?

A No.

Q Are you aware of any of the names of the specific opioids at issue in this case?

MR. PATE: Object to form.

A They are all OxyContin or MS Contin -- they're -- they're all in that family -- oxycodone. I'm not familiar with proprietary names, if that's what you're asking.

Q (By Mr. Bartle) Okay. But you don't know the exact names of -- of the opioids at issue in this case?

A I have not studied them specifically, no.

Q And are you aware of the specific manufacturers who are being -- who are sued in this case?

A I can recall a -- a few that are in the -- in the document.

Q Have you ever had any contact or dealings with any of those manufacturers?

A I assume, at some point, I may have bought a medicine from some of them, as a -- as a consumer, but, other than --

Q Beyond that?

A -- that, no. No.

Q And are you opining on whether the current opioid epidemic in Oklahoma was foreseeable?

A I am opining on that in the sense of the historical precedents that could touch upon the case and

that are built into the control and regulatory system I've been talking about.

Q And so it would have been foreseeable by, for example, the FDA?

MR. PATE: Object to form, calls for speculation.

A It is foreseeable to any particular entity on this circle, if they have the proper information from the other actors in the system.

Q (By Mr. Bartle) And you're talking about Exhibit 4 when you say "circle"?

A Yes, Exhibit 4, yes.

Q Thank you. Are you opining upon the cause of the current opioid epidemic in Oklahoma?

A I am commenting on the historical perspective that can inform the cause.

Q But I'm asking about the actual cause. Are you giving an expert opinion --

A No.

Q -- on the actual cause of the opioid epidemic in Oklahoma today?

A No.

Q And you're not opining on whether or not the pharmaceutical manufacturers caused the current opioid epidemic in Oklahoma today?

A I'm sorry, say again.
Q You're not opining upon whether the -- on whether the pharmaceutical manufacturers sued in this case caused that current opioid epidemic?
A No.
Q Are you opining on the appropriateness of actions taken by third parties, including international actors, federal governments, state governments, insurers, with re- -- and insurers -- with regard to the prevention or exacerbation of the current opioid epidemic in Oklahoma?
MR. PATE: Object to form.
A No.
Q (By Mr. Bartle) Are you a causation expert?
MR. PATE: Object to form.
A What do you mean by "causation expert"?
Q (By Mr. Bartle) Well, are you an expert in determining what caused, for example, the present opioid epidemic in Oklahoma?
A No.
Q Did you make any assumptions in forming your opinions?
A Did I make any assumptions?
Q Yeah.
A Well, yes, I mean, one -- when working with

archival material, one makes an assumption that you have seen the most relevant documents, for example. I mean, there's all sorts of assumptions that's built into the methodology of being a practicing historian, that are based on the -- what the discipline does. If that's what you mean, yes.

Q And does -- I know you -- you highlighted it later, but does the long paragraph on Exhibit 5 --

A Uh-huh.

Q -- Paragraph 9 --

A Uh-huh.

Q -- on Page -- does that outline the method that you used in coming to your opinion outlined in the disclosure in this case?

A Yes. Generally speaking, this is a very brief description of the craft of being a historian.

Q And you're not making any expert -- you're not giving any expert opinion specifically as to the opioid epidemic in Oklahoma, are you?

A No.

MR. BARTLE: Can we have a couple minutes?

MR. PATE: Yeah.

THE VIDEOGRAPHER: Going off the record. The time is 1:54.

(Recess was had from 1:54 p.m. to 2:14 p.m.)

THE VIDEOGRAPHER: We're back on the record. The time is 2:14.

MR. BARTLE: Doctor, thank you very much for your time today. I don't have any further questions. I pass the witness.

THE WITNESS: Okay.

MS. DANIELS: No questions from Janssen.

MR. McANANEY: No questions from Purdue.

MR. PATE: Okay, let's go off the record.

THE VIDEOGRAPHER: Going off the record. The time is 2:14.

(Recess was had from 2:14 p.m. to 2:16 p.m.)

THE VIDEOGRAPHER: We're back on the record. The time is 2:16.

EXAMINATION

BY MR. PATE:

Q Good afternoon, Dr. McAllister.

A Good afternoon.

Q My name -- as you know, my name is Drew Pate and I represent the State.

Do you have Exhibit 3 still in front of you?

A Yes.

Q And is Exhibit 3 a summary of the facts and opinions that you intend to offer in this case at trial?

A Yes.