EXHIBIT E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KEITH ROGERS, et al.,

Plaintiffs,

vs. No. 1:15-cv-11632

SHERIFF OF COOK COUNTY, et al.

Defendants.

The Deposition of DR. JASDEEP MANGAT, taken remotely before JEANINE WATKINS, C.S.R., pursuant to the provisions of the Federal Rules of Civil Procedure of the United States District Court, pertaining to the taking of depositions, commencing at the hour of approximately 8:00 a.m. Central Time on September 29, 2022.

A P P E A R A N C E S:
(All parties participated remotely.)

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A. 2005 to 2009.
Q. And what did you major in?
A. Biochemistry and Cell Biology.
Q. And then did you work at all while you were in college?
A. I did not.
Q. After college did you attend any further school?
A. I did.
Q. And what was that?
A. I went to medical school.
Q. And where did you go to medical school?
A. Baylor College of Medicine in Houston.
Q. And what years?
A. 2009 and graduated in 2014.
Q. And then did you complete a residency after that?
A. I did.
Q. And where did you complete that residency?
A. At Montefiore Hospital in New York City.
Q. And what were your duties at Montefiore Hospital?
A. I was a resident physician in internal medicine. I had an outpatient practice as well as

Q. What year was that?
A. That was in 2014.
Q. Did you study that concurrently with medical school, or was that during your residency?
A. With medical school.
Q. After your residency what was your next employment in the medical field?
A. My next employment was at Rikers Island in October of 2017, while simultaneously I was also working internationally doing a global health and clinical skills fellowship in Uganda.
Q. And when you started at Rikers Island what was your title?
A. Attending physician.
Q. Was that like an internist?
A. Yes. As an internal medicine doctor, yes.
Q. When you first started did you do any work with -- strike that.

I refer to it as the OTP or the KEEP program. I don't know what's the easiest way to address that during the deposition, if you have a preference.

A. KEEP program would work.
Q. So for the record, what is the KEEP program

medicine at Rikers?

A. Until about end of June, 2018. So beginning of July of 2018.

Q. What was your next role at Rikers after that?

A. The deputy medical director of the KEEP program. .

Q. Why did you make the move to the KEEP program at that point?

A. At that point I had been turning -- I was interested in treating individuals with substance use disorders. That position had opened up recently, and it was a nice fit for my interests.

Q. What were your duties as the deputy director?

A. It was a mixed set of duties, but it included taking care of patients with substance use disorders as well as administrative tasks as it related to the KEEP program.

Q. What sort of administrative tasks?

A. One would be at that time we were offering -- we were expanding our access to buprenorphine in Rikers Island. So coordinating around expansion of buprenorphine in the jails, letting other physicians

Q. Do you maintain the licenses?
A. Yes.
Q. Jumping back, after you were the deputy director at Rikers what was your next position?
A. Medical director of substance use treatment.
Q. Is that the same thing as head of the KEEP program, if I say that correctly?
A. Yes.
Q. When did that happen?
A. January of 2020.
Q. How long were you the medical director of the KEEP program?
A. Until September, 2021.
Q. And then did you leave Rikers at that point?
A. Yes.
Q. What was your next position? What did you leave Rikers for?
A. I left Rikers in September, 2021, to move with my wife to Rwanda.
Q. And are you currently working in Rwanda?
A. Yes.
Q. What are you doing in Rwanda?

going through a significant amount of withdrawals and if I had an opportunity to see them or another physician to see them, we would also occasionally maintain them on 20 milligrams until we could verify their dose.

Q. Assuming it was normal, under normal circumstances, how long between when a new detainee was first seen by the intake at Rikers would they be provided with their first dose of methadone or buprenorphine?

A. Within a few hours.

Q. Generally how are -- if you know, how are opioid treatment programs regulated?

A. By the federal government's guidelines set forth by SAMHSA, which is the Substance Abuse and Mental Health Services Administration.

Q. And that's the same professional facility?

A. Yes. SAMHSA will certify an OTP, but in a correctional facility, NCCHC, the National Commission For Correctional Healthcare, is the body that will go in and do an audit and a credit, an OTP in a correctional setting.

Q. Are you familiar with the Code of Federal Regulations over the opioid treatment programs?

certification or accreditation?

A. Not directly. During the accreditation process I didn't have any -- when I was there I was a deputy medical director, and that was the -- the accreditation process was the committee was spearheaded by the medical director and other people within the program.

Q. One of the main reasons we're here today is talking about the OTP at the Cook County Jail. Do you know if the Cook County Jail OTP was certified by SAMHSA for the class period?

A. I do know. They were.

Q. Same question with accreditation through NCCHC. The Cook County OTP was accredited the entire time; is that right?

A. Yes.

Q. What is SAMHSA?

A. SAMHSA the organization on the Department of Health and Human Services that is in charge of the regulation of opioid treatment programs in the country.

Q. And do they release federal guidelines?

A. Yes.

Q. So I'm going to show you what's been marked

Q. Okay. Do you have an opinion as to whether or not the Cook County Jail's OTP policies violate any of the SAMHSA guidelines?

A. They do not, based off the fact that they received certification by SAMHSA.

Q. Do you know if -- strike that.

In order to receive certification from SAMHSA does an OTP have to submit their written policies?

A. Yes.

Q. Is that something Rikers did?

A. Yes.

Q. And as far as you know that's something that Cook County Jail did?

A. Yes, as far as I know.

Q. And to make my defendant co-defense counsel I will spell this out.

When I say the OTP, the Cook County Jail, are you familiar with the -- if I say Cermak do you know what I'm talking about?

A. Can you clarify just so I make sure?

Q. I just want to make sure we're all on the same page here. Cermak is the medical provider, a portion of Cook County that's the medical provider

at the Cook County Jail. So if I say Cermak on the Cook County Jail, I'm talking about the medical staff who treats patients at the Cook County Jail.

A. Okay.

Q. That's fair to say?

A. Yes.

Q. Okay. Because I've been doing this so long, in many occasions we go back and forth and I don't want to confuse anybody.

Same questions about the -- strike that.

So you also talked about the accrediting body, the NCCHC. That's the National Commission on Correctional Healthcare, correct?

A. Yes.

Q. And what is the NCCHC?

A. They are the accrediting body directly as it relates to OTPs that will come in and audit an opioid treatment program and provide -- whether or not they pass accreditation or not, and that's the indication for SAMHSA to certify an OTP or not.

Q. And you say they audit. Well -- strike that.

Does the NCCHC, I think you already said they did accredit the KEEP program, correct?

A. Yes.

Q. And you mentioned that they audit the program. What do those audits entail?

A. The audits entail a visit by representatives from NCCHC that will come in and look at the policies of the OTP as well as looking at evidence that those -- that that OTP is meeting all the clinical standards set forth by the NCCHC.

Q. Does the -- does the individual OTP also, are they required to provide copies of their policies to the NCCHC?

A. I don't know if they are required to provide copies as much as I know that the NCCHC reviews the policies on site.

Q. So the NCCHC is aware, is familiar with the written policies of any OTP that they accredited; is that fair to say?

A. Yes.

Q. In this case, you know, there are two different issues, but in particular you are critical of the tapering policy at the Cermak OTP. Is that fair to say?

A. Yes.

Q. Was that policy -- was that policy, strike

that.

Was the tapering procedures at Cermak during the class period set forth in their written policies?

A. Can you explain what exactly you mean by their tapering policy?

MR. FLAXMAN: Let me suggest this might be a good time to take a five-minute break.

MR. HENRETTY: Sure. Yes. I'm sometimes bad about that, but absolutely that's fine with me.

(There was a discussion held off the record.)

BY MR. HENRETTY:

Q. Doctor, we were talking about NCCHC accreditation and audits before we took a break. You mentioned that they, NCCHC would review the policies during these audits of the OTP. What else do those audits entail?

A. They also go to tour the facilities, tour the medication of patients as well as meet with patients.

Q. Would they do chart review?

A. I don't know.

Q. Did you have any opinion in this case as to

whether or not the OTP at the Cook County Jail was in compliance with NCCHC guidelines during the class period?

A. They were.

Q. I'm going to briefly show you -- can you see that, Doctor?

A. Yes. I can see this.

Q. I'll mark that as Exhibit 2.

(Exhibit Number 2 was identified for the record.)

Can you tell me what this document is?

A. Can you scroll down?

Q. Absolutely. I'll tell you it's not the entire document. It's just a few sections of it.

A. Yeah. It's the NCCHC standards.

Q. And that's from 2016?

A. Yes.

Q. Do you know if that's their most recent set of standards?

A. It is their most recent.

Q. And there is some handwriting on the top that obviously is not part of the actual official manual, as I assume?

A. No. It is not part of their official

A. It doesn't specify in O-E-05 if they are referring to somebody coming on opioid agonist or opioids in the community that they are using recreationally.

Q. Is there a difference in treatment between someone who is withdrawing from an opioid agonist versus someone who is withdrawing from another kind of opioid?

A. No.

Q. In your expert report you mention the American Society, or you cite to the American Society for Addiction Medicine. ASAM. Is that the right acronym for that?

A. Yes.

Q. What -- when I say ASAM I mean the American Society For Addiction Medicine. What is ASAM?

A. ASAM is an organization of addiction medicine doctors that in their guidelines set forth recommendations around certain diagnoses and treatment of certain diagnoses as it relates to addiction medicine.

Q. Are you a member of ASAM?

A. I am not a member of ASAM.

Q. Does ASAM have any regulatory authority?

as MAT, with FDA approved medications such as methadone or buprenorphine. Did I read that correctly?

A. Yes.

Q. What is medication assisted treatments or MAT?

A. It's the treatment with -- it's the treatment with medications for individuals that have opioid use disorders. And the examples they give here are methadone, buprenorphine, or even naltrexone.

Q. Are there any other, just so I know the universe that I'm talking about, are there any other drugs that you are referring to when you say MAT other than those three, for purposes of this case?

A. No.

Q. What is methadone?

A. Methadone is an opioid, a long-acting opioid.

Q. And why is it used as medication to treat addiction to other opioids?

A. Well, one, there is a longer half life with methadone as opposed to opioids such as heroin, morphine, oxycodone. And so it generally can

require about once a day dosing with individuals. So it's one of the reasons. As well as it doesn't have as much of a peak effect as some of the other opioids, so there is less of a euphoria that is associated with it.

Q. Is there any euphoria associated with methadone?

A. My understanding is there is some.

Q. Can you quantify that? Is it 10 percent of heroin, 50 percent?

A. I cannot.

Q. You use the phrase half like or the term half life. What does half life mean?

A. Half life is the time it takes for the medication to be reduced by half in the body.

Q. And what is the importance or relevance of the word -- strike that.

What is the importance of the word half life in this context?

A. In this context, half life is important as it relates to when -- how long it takes before someone might start to feel the withdrawal effects of an opioid.

Q. And do they start to feel the withdrawal

also affect an EKG.

Q. If I use this phrase right, are there any medications that are contraindicated for methadone?

A. I don't know right now if there are any that are contraindicated, but I do have -- I would not give other opioid -- I would not give other sedating medications with methadone.

Q. Why not?

A. Because of the risk for sedation.

Q. Is it -- if you're on methadone and you -- if one is on methadone and they also take another opioid, either, let's say an illegal opioid like heroin, how would that affect them?

A. It depends on how long they've been taking methadone, what's their dose of methadone, how much of heroin they are taking, is it laced with fentanyl, how are they taking it, when are they taking it.

Q. What is buprenorphine?

A. Buprenorphine is a partial opioid agonist.

Q. And partial versus methadone, which is a whole opioid agonist or a total opioid agonist?

A. Full opioid agonist.

Q. Full. Thank you. What does it mean to be

a partial opioid agonist?

A. It means within the terms of pharmacal kinetics that with buprenorphine you'll get a ceiling effect. Effectively at some dose you don't necessarily have the same effect that you might have if you are increasing from a lower dose.

Q. What does -- medically what does buprenorphine do? Is it the same as -- that's different than methadone?

A. It actually functions pretty similarly as methadone in that it is also an opioid agonist and binds to opioid receptors just like methadone does.

Q. Are there benefits taking buprenorphine as opposed to methadone?

A. There are benefits and risks as compared to methadone. And I think every individual has preferences depending on their circumstances and context.

Q. Can you tell me what the benefits are?

A. With buprenorphine, the benefit is you don't have to go in to an opioid treatment program if you're in the community every day to get medicated. So usually individuals will go once every two weeks or once every month to see their

A. Naltrexone is an opioid antagonist.

Q. What is an opioid antagonist as opposed to an opioid agonist?

A. It completely blocks the opioid receptors in your body as opposed to binding it like an opioid agonist.

Q. And why is that given as opposed to the other two? Under what circumstances, I should say?

A. Again, it's patient preference. If they don't want to be on an opioid agonist and they want, much rather not risk even taking it, taking any opioid or feeling any effects of opioid, they prefer to be on naltrexone.

Q. Naltrexone doesn't have any sense of euphoria, I would assume?

A. No.

Q. Does buprenorphine?

A. It can, yes.

Q. What are the side effects of naltrexone?

A. The biggest side effect to worry about with naltrexone is if you have any opioid in your system it can cause immediate withdrawal if you're taking naltrexone.

Q. Does it have any -- does it lessen

Q. In your opinion, are there any limitations on providing MATs in jails that are different from limitations in the community?

A. Absolutely.

Q. And what are some of those limitations?

A. The biggest limitation is, for one, getting all of the jails and prisons in the system to offer medication assisted treatment. I would say that's the first limitation.

The second limitation is being that the individuals are incarcerated or detained, having to do daily observed therapies for every individual including for buprenorphine while dealing with the challenges of housing, escorting patients to get their medication, to go see medical, alarms that might be going off during these circumstances, just to name a few of the challenges that are different from the community.

Q. You mentioned, and we'll talk about this kind of throughout, but you mentioned that one limitation was getting jails and prisons to offer MAT. Do you know today roughly how many -- start with jails in the country, we're in different countries right now, in the United States, offer

MAT?

A. I don't know roughly how many.

Q. Do you know if it's more than 50 percent?

A. It's not more than 50 percent. It's less than 50 percent.

Q. Do you know if it's more than 10 percent?

A. I don't know.

Q. How about 20 percent? Do you know if it's more than 20 percent?

A. I don't know. My impression, my best guess would be it's less than 20 percent, but I can't say that with certainty.

Q. Has that number changed since 2013?

A. Yes.

Q. How has it changed?

A. It's increased.

Q. So in 2013 it would have been less than it was now?

A. Yes.

Q. Would it have been significantly less than it was now?

A. Hard to say. I don't think it's probably that much different, to be completely honest, but I'm not entirely sure.

Q. We'll come back to that a little bit later.

Opinion Number 2, if I'm reading this correctly: Forced opioid withdrawal of individuals with OUD, which includes tapering prescribed agonist medication can cause undue harm -- sorry. Tapering prescribed agonist medication can cause undue harm and suffering, while placing these individuals at an increased risk of relapse, overdose, and death.

Did I read that correctly?

A. Yes.

Q. Can you define forced opioid withdrawal for me?

A. I would say individuals that did not choose to go through withdrawal of their opioid agonist treatment.

Q. Is there a difference in your mind or in your opinion between forced opioid withdrawal through tapering and forced opioid withdrawal from stopping the treatment without tapering, meaning immediately?

A. There is a difference between those two.

Q. And what would that difference be?

A. The difference is the withdrawal effects will be notably more with those that are stopped

completely as opposed to going through a taper.

Q. Of those two situations, which is better for the patient, tapering or stopping without tapering?

A. Tapering.

Q. Is it, would you say, significantly better for the patient? Can you quantify it?

A. Without a doubt, better.

Q. Have there been any studies that you're aware of on this or peer-reviewed journal articles or anything like that on tapering versus stopping immediately?

A. I am not personally aware of those articles, though I imagine they exist.

Q. Just because it's easier, if I say the phrase, cold turkey, to mean stopping without tapering or any other fanfare, does that make sense to you?

A. Yes.

Q. The phrase. Okay. In this case, this class action, there are three named plaintiffs. Are you aware of that?

A. Yes.

Q. Do you know if the three named plaintiffs

A. I am not aware.

Q. Are you aware if any class members died in this case after there --

A. I am not aware.

Q. Let me just go back to your third statement. Your third opinion is that the delay in the administration of the OTP prescriptions like methadone or buprenorphine will result in the worsening of or onset of withdrawal symptoms.

Did I read that correctly?

A. You did.

Q. Does every patient who has tapered off of methadone suffer withdrawal symptoms?

A. Not necessarily.

Q. About how many? Can you make a percentage on that, what percentage do suffer and which ones don't?

MR. FLAXMAN: I'm going to object to the form of the question. It's not specified as to what you mean by tapering.

BY MR. HENRETTY:

Q. Well, as it's been described. It was defined by the witness earlier today.

Do you have a sense of a percentage as to

which patients suffer withdrawal symptoms and which ones don't?

A. I don't -- I'm not able to put a percentage, but I can say from my personal experience the majority of individuals who go through a taper, particularly an involuntary, forced withdrawal, are going to go through withdrawal.

Q. Are going to go through withdrawal?

A. Are going to go through withdrawal symptoms.

Q. Does that change -- in your experience, does the level of severity of the withdrawal symptoms change based on the length of time and the amount of the taper?

A. Yes.

Q. How so?

A. If the taper is -- if the length of time is longer or the taper is shorter, meaning not -- like the amount that they decrease every time, and that they go through a longer period from the point in which they start and the point in which they finish the taper, usually is tolerated better than if it was a shorter amount of time in which they underwent the taper.

Q. As far as the onset of symptoms for -- or withdrawal symptoms, when would you expect or when have you experienced in your work what you have experienced watching or a detainee going through withdrawal, when do the symptoms onset? Is that immediately upon starting the taper? Is there a set period of time? Does it depend on anything else?

A. It depends on a variety of factors. It depends on their last dose of methadone. It depends on how often they've been taking it prior to that. It depends on their own individual, I think, genetic makeup in terms of how they metabolize. Other medications they might be on. Just to name a few of the factors that can affect half life and can affect onset of withdrawal symptoms.

Q. How would their metabolism affect the onset of withdrawal symptoms?

A. Within methadone there are some individuals that can be rapid metabolizers of methadone. And so what I mean by that is the enzymes that metabolize methadone, depending on each individual, metabolize on a different rate which cause a variability on the half life of methadone depending on the person.

Q. What withdrawal symptoms do you associate

with withdrawal from methadone?

A. It's the same withdrawal symptoms I expect from individuals that are withdrawing from any opioid. And those symptoms could be diarrhea, sweating, anxiety, tremor, restlessness, nausea, vomiting, just to name a few. Agitation.

Q. And I know that the severity of that probably, as we sort of discussed, can change person to person, but is it a -- how dangerous are the withdrawal -- how dangerous is withdrawal from, let's start with cold turkey? Strike that.

If a patient quits an opioid agonist like methadone, cold turkey, how severe would you expect the withdrawal symptoms to be?

A. I would expect them to be severe, assuming that they were taking the medication every day and on a regular basis for an extended period of time, more than a few weeks.

Q. How dangerous would those withdrawal symptoms be?

A. Dangerous because of the biggest risk in my opinion is that when someone is going through withdrawal, the risk of relapse and overdose from that relapse is quite high.

arrived at the Cook County Jail on 23rd, got the first dose on the 25th, it's your opinion that at least some of the withdrawal effects he was experiencing are related to his not taking methadone, right?

A. Yes.

Q. Do you know when the Cook County Jail OTP staff was able to verify his dose?

A. I -- my understanding based off Dr. Richardson's report, it was done December 24th.

Q. And that, you mentioned earlier that the holidays sometimes slow down getting responses from OTPs in the community?

A. Yes.

Q. And that December 24th being Christmas Eve?

A. Yes.

Q. And the OTP wouldn't have been able to start that process until he arrived at the Cook County Jail. Would you agree with me on that?

A. Yes.

Q. How would you be able to determine -- well, strike that.

Does withdrawing from heroin and withdrawing from methadone, did those cause the same

withdrawal symptoms?

A. Yes.

Q. How would you, one, be able to tell the difference between withdrawing from heroin and withdrawing from methadone?

A. You wouldn't.

Q. Does one overpower the other, meaning is the heroin withdrawal worse than the withdrawal from methadone or are they the same?

A. I don't think you can say one is worse than the other.

Q. Would they be compounded if you were withdrawing from both at the same time?

A. Yes.

Q. So it would be worse to withdraw from both heroin and methadone than it would be to withdraw from one or the other?

A. Yes.

Q. And then is it your understanding that Ms. Hollins arrived on September 12th and received her first dose on September 13th of the year she was incarcerated?

A. Yes. But also her last dose of methadone was on September 11th.

than if you started at 200 and reduced by 50?

A. That is correct.

Q. The last written opinion or the last identified opinion is: Tapering individuals off their prescribed opioid agonist medication because the treatment will be discontinued in the event the detainee is transferred to IDOC causes unnecessary harm to the individuals who enter the Cook County Jail to serve a misdemeanor conviction, and ignores the fact per my understanding that less than 15 percent of individuals who enter the jail serve time in the Illinois Department of Corrections (IDOC). Did I read that right?

A. You did.

Q. So as we discussed, tapering being better than cold turkey, would you agree with me that the 15 percent -- I know it's -- let's call it 15 percent -- of individuals who went into the Illinois Department of Corrections benefitted from the taper?

A. Versus going cold turkey?

Q. Yes.

A. Yes.

Q. And let me ask you that. Are you aware whether or not the Illinois Department of

Corrections provides any MAT?

A. I'm aware that during this class action the timeframe from the class action lawsuit base did not offer MAT.

Q. So it would have been worse for them if they had not tapered and gone cold turkey in the IDOC?

A. Yes.

Q. Do you know what percentage of detainees are released from the Cook County Jail and then directly transferred into another county pursuant to a warrant?

A. I am not aware.

Q. Do you know if there is any other county jail in Illinois that offers MAT?

A. As far as my understanding, there is not any other jail in -- this is Cook County, correct?

Q. Yes, correct.

A. Yes. No other jail in Cook County offers MAT.

Q. No. There is no other jail in Illinois?

A. Sorry. Correction. There are no other jails in Illinois that offer MAT as far as my understanding.

the time scale of their dose reduction was dictated less by their individual medical needs and more by charges or for administrative expediency.

Do you see that?

A. Yes.

Q. Was that the policy at Rikers at the time?

MR. FLAXMAN: Objection. Was what the policy of Rikers?

BY MR. HENRETTY:

Q. Was it the policy of Rikers at the time to detoxify the patients who were being sent -- who had been sentenced to felonies?

A. I don't have personal knowledge about that, but that is my understanding.

Q. That's still the policy today if they are over two years, is that right, or at least it was when you left? If they were sentenced to more than two years you were withdrawn from methadone?

A. When I left Rikers that was the policy.

Q. And then was that a violation of the standard of care in your opinion in 2015?

A. Well, was what a violation of the standard of care?

Q. Tapering the patient, or the detainees, off

of methadone prior to sending them to state prison.

A. Yes.

Q. Is it still a violation of the standard of care since they were doing it now -- or they doing it there when you left? Excuse me.

A. Yes.

Q. And that was the case when you were running the program as well?

A. What was the case?

Q. It was the case that they did taper inmates off of methadone prior to sending them to state prison?

A. Yes. And that was a violation of the standard of care.

Q. If you look under that same Rapid Dose Reduction section, some phone quotes from detainees who were talking about the detox. Do you see those? Hold on. I'll have to show them to you. There is one on the bottom here and then another two at the top. I don't know if I can get -- I can't see exactly what you guys are seeing, so I don't know if you are seeing them or not.

You see where it says: It was amazing because?

A. A standard of care would be a general consensus or practice around a treatment of a specific disease.

Q. You mentioned earlier you that you thought that Rikers while were you there and to this day is violating the standard of care by not continuing MAT treatment for OUD patients; is that right?

A. No. Because I did not say up to this day.

Q. Up until the time you left?

A. Correct.

Q. Okay. When you were a deputy director and then the director of the KEEP program, were you involved in policy making?

A. Correct. Yes.

Q. Did you make any efforts to change the tapering policy while you were there?

A. Absolutely. In fact, while I was there, the state prison systems were to offer methadone as a treatment and then started to change to the point where we could offer treatment for those individuals, and they were, as the time that I left, they were in the process of expanding access to all individuals no matter their sentence. For more than two years they can maintain methadone even if

A. Can you repeat what you mean by "paid them to"?

Q. They paid for it. They paid for the CMAT?

A. Correct.

Q. And this is 2015 when Rikers was still tapering all people who were charged with a felony up to two or more years in jail, right?

A. That is correct.

Q. Was there any jail in the country who was providing MAT for detainees in 2015 where they didn't taper them; do you know?

A. I am not aware of that. I don't know.

Q. I am -- oh. Real quick. What's -- Exhibit 15 says letters. This is a letter. What is a letter compared to a research article?

A. I don't know the exact criteria for a research letter, but it's a research paper, so I can't speak to the difference.

MR. HENRETTY: I think I am just about done. I'm going to take a minute to circle up here and check, and I -- my colleagues here may have some questions as well. Why don't you give me one minute and I'll let you know, and say five minutes and I'll let you know if I have further questions. Okay?