Alaska's North Slope to the rest of the country.

Senator DOMENICI's amendment is not all about natural gas. For electricity, about which many of my colleagues have spent a great deal of time talking on the floor, the amendment ensures reliable and affordable electricity for America.

We all recognize that we in Congress must address the issue of reliability. The amendment would prohibit onerous Federal manipulation of energy trading markets that cost consumers money, and it would increase the penalties for market manipulation and enhance consumer protections.

To those of my colleagues who have called on the Senate to address the electricity issue, the reliability issue, I say support Senator DOMENICI's proposal.

For coal, which is used to produce 50 percent of our Nation's electricity, the amendment authorizes $2 billion to fund the Clean Coal Power Initiative. The development of clean coal technology will help our Nation use its abundant coal resources in an environmentally responsible manner.

In Alaska, we are working to find new ways to use our very abundant reserves while mitigating the impact on our environment. We have a little place called Healy, AK, where we have a small experimental clean coal plant. This clean coal plant is currently sitting dormant. It just barely missed its emissions requirement. We were attempting to utilize new technology to again provide very necessary energy to an area that was very limited in what it could receive and what it could generate. Once the Healy clean coal plant and other clean coal technologies demonstrate better ways for us to generate electricity from coal, we can utilize our Nation's vast coal resources in an environmentally responsible manner for many years to come, as well as provide high-paying jobs and much needed electricity.

There is also renewable energy. For renewable energy, the amendment reauthorizes the Renewable Energy Production Incentive Program to promote the use of clean renewable energy. The amendment would also encourage exploration and development of geothermal energy, including a call for rulemaking on a new royalty structure that encourages new production.

I could go further in detailing all those very important matters contained in the energy amendment, but I think these four examples—authorizing the Alaska natural gas pipeline, improving our Nation's electricity grid, providing research on clean coal technology, and promoting the use of clean renewable energy—illustrate the immense benefits of a comprehensive energy policy. They are great, but they are meaningless to us unless we enact them.

A comprehensive national energy policy, as envisioned in Senator DOMENICI's amendment, will generate thousands of jobs throughout the country. As I said on many occasions, the Energy bill is a jobs bill. So is this amendment.

I commend the Senator from New Mexico for offering this amendment. I know my constituents in Alaska don't care whether this bill is enacted as an amendment or as a stand-alone bill. My constituents want to see the jobs. My constituents want to see the energy, they want to see the natural gas, and they want to see movement on an energy policy. I think most Americans want the same thing. They want high-paying jobs. They want decreased volatility in the energy market. They want increased use of renewable energy and improved electricity grids. I think we have that within this amendment.

I urge my colleagues as we move forward to support the amendment of the Senator from New Mexico.

I thank the Chair. I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. MCCAIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. MCCAIN. Madam President, I ask unanimous consent at this time the Senate proceed as if in morning business until 2:55, and the Senate will recess for approximately 1 hour because Secretary Rumsfeld will be briefing Members in room 407. I amend my unanimous consent request that the Senate reconvene at 4 p.m. today.

Mr. REID. If the Senator would modify his request, at that time we come back on the bill.

Mr. MCCAIN. Return to consideration of the McCain substitute.

Mr. REID. Reserving the right to object, I appreciate very much the request of the Senator from Arizona. It is appropriate. By 4 o'clock we will know what position we are in on both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. ALEXANDER. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ALEXANDER. Madam President, I ask unanimous consent I be allowed to speak as in morning business.

The PRESIDING OFFICER. The Senator has that right.

Mr. ALEXANDER. I understand the President pro tempore may be coming to the Senate floor. If he appears, I will yield to him and pick back up when he finishes. In fact, the President pro tempore has arrived.

I yield the floor to the Senator from Alaska until he finishes.

PRAISE FOR MILITARY MEDICAL COMMUNITY

Mr. STEVENS. Madam President, the Senator is very kind, and I thank the Senator from Tennessee.

Madam President, I come to the floor today to inform the Senate of the outstanding commitment, courage, and professionalism of our military medical community. This morning, the Senator from Hawaii and I cochaired a hearing with the Surgeons General and the chiefs of the Nursing Corps from each branch of the Armed Forces. We were joined by Army Surgeon General James Peake, Navy Surgeon General Michael Cowan, and Air Force Surgeon General George Taylor. From the Service Nursing Corps, we heard from Army COL Deborah Gustke, Navy ADM Nancy Lescavage, and Air Force GEN Barbara Brannon.

I want the Senate to note and personally thank each of our witnesses today for the outstanding leadership they provided to our military medical community. Their individual accomplishments are numerous.

I offer a special recognition to Surgeons General Peake and Cowan, who will be retiring from Active Duty this year. We greatly appreciate their service in military medicine, to our Nation, and especially their assistance to the Appropriations Subcommittee on Defense. The insight they provided to the subcommittee is invaluable. I congratulate each one of them on a successful and distinguished career.

During today's hearing, the members of the committee and I were told of outstanding accomplishments by our military medical leaders. I have come to the Senate to share some of what we learned today with my colleagues.

Over the last year, our thoughts have never been far from the battlefields, or from the soldiers and families who have sacrificed so much for our Nation. I salute our brave soldiers, sailors, airmen, and marines for their efforts in the war on terrorism. I join the families of our lost sons and daughters in mourning and remembering those who made the ultimate sacrifice in the defense of freedom.

I have seen many headlines about the casualties of the war, but the accomplishments of our military doctors, nurses, and corpsmen are seldom mentioned. These health care professionals were among the first to rush to the battlefield, and they are still on the front lines providing care in some of the most dangerous and difficult conditions.

Today our combat medics regularly perform miracles. They use transformational technology to successfully expand the ''golden hour'' of trauma care, the critical hour of opportunity from when a trauma is sustained and the lives can be most often saved.

One telling statistic is the lowest ''died of wounds rate'' in recorded history of warfare.

A number of factors have contributed to this accomplishment, but the mobile surgical teams have been crucial. They bring resuscitative surgical care onto the battlefield. Without the care they get within the ''golden hour'' after being wounded, the 15 to 20 percent of wounded soldiers they target would probably die while being evacuated to the combat support hospital.

These surgical teams are specially equipped to deal with excessive hemorrhaging, which has been the major cause of death in previous conflicts. One of the transformational technologies employed by these surgical units is a hand-held ultrasound machine used to identify internal bleeding, a truly lifesaving piece of equipment.

Other technologies the medics have employed include haemostatic dressings and the chitosen bandage. These are two new lifesaving wound dressings that are being used in Iraq and Afghanistan.

Approximately 1,200 haemostatic dressings have been deployed under an investigational new drug battlefield protocol. In one account we learned of today, the dressing was successfully applied to a thigh wound to completely control arterial bleeding when a pressure dressing and tourniquet proved unsuccessful. There are two similar reports of special forces medics using chitosen bandages to treat severe bleeding caused by gunshot wounds to the extremities. Approximately 5,800 of these chitosen bandages have been deployed to the theater of operations.

These are just a few of the examples of military medics using revolutionary medical technologies to lead the way in trauma treatment, lead the way in saving lives. Military researchers continue to investigate numerous other cutting-edge technologies, and those efforts are the foundation for the future of medical health care while in the service. Many of these same technologies will likely be used someday in civilian trauma centers across our country.

Aeromedical and ground evacuation crews, operating from Blackhawk helicopters, a variety of fixed-wing aircraft, and ground evacuation vehicles, such as the Stryker, have also performed exceptionally during operations in Iraq and Afghanistan. The crews have demonstrated an ability to swoop into a hostile environment and pull wounded service members from the battlefield. They provide critical in-flight trauma care until more substantial care can be provided at fleet and field hospitals.

Military health professionals also ensure the health and safety of our soldiers in a number of other ways. When forces deploy around the globe, environmental health professionals are on the ground surveying the environment for biological and environmental threats. Among these military health professionals are nationally recognized experts in chemical, biological, radiological, and nuclear threats. Their expertise ranges from medical surveillance and epidemiology to casualty management. Chemical, biological, radiological, and nuclear training has been incorporated into the soldiers' common skills training, advanced individual training, and leadership courses.

Our health professionals also consider the mental health of our troops to be a top priority. In July 2003, a team of mental health experts from treatment facilities around the Nation left for Iraq. Their mission was to assess mental health issues and address concerns about a spike in the number of suicides occurring in the theater of operation. These professionals evaluated the mental health patient flow from theaters and assessed the stress-related issues soldiers experienced in combat operations.

The survey team remained in the theater for 6 weeks and traveled to several base camps. I am told this is the first time a mental health assessment team has ever conducted a mental health survey with soldiers in an active combat environment.

While many of the medical providers are deployed in the support of contingency operations, the military health system continues to provide outstanding care to service members, their families, and our retirees here at home.

These professionals never waiver in their commitment to the highest quality of health care for our beneficiaries.

The caregivers here at home also provide rehabilitative care to our troops after returning from combat. Perhaps the best example is the amputee center at Walter Reed Army Medical Hospital, which provides state-of-the-art care to service members who have lost limbs in battle. The center aims to return each amputee to the highest level of performance and quality of life. I have personally visited with wounded soldiers at the center, and I can tell you they are achieving their goal.

I have come to the Chamber to commend our military health care professionals who have served with distinction throughout the global war on terrorism. Their dedication and commitment to their fellow service members is unmistakable, and their service is responsible for saving countless lives, both of our American service members and injured Iraqis. We are truly grateful for their service.

I ask the whole Senate to join me in commending the military service of these medical professionals who have done so much for us.

I ask unanimous consent that the article from the Washington Post of April 27, entitled ''The Lasting Wounds of War,'' by Karl Vick, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE LASTING WOUNDS OF WAR

(By Karl Vick)

BAGHDAD.—The soldiers were lifted into the helicopters under a moonless sky, their bandaged heads grossly swollen by trauma, their forms silhouetted by the glow from the row of medical monitors laid out across their bodies, from ankle to neck.

An orange screen atop the feet registered blood pressure and heart rate. The blue screen at the knees announced the level of postoperative pressure on the brain. On the stomach, a small gray readout recorded the level of medicine pumping into the body. And the slender plastic box atop the chest signaled that a respirator still breathed for the lungs under it.

At the door to the busiest hospital in Iraq, a wiry doctor bent over the worst-looking case, an Army gunner with coarse stitches holding his scalp together and a bolt protruding from the top of his head. Lt. Col. Jeff Poffenbarger checked a number on the blue screen, announced it dangerously high and quickly pushed a clear liquid through a syringe into the gunner's bloodstream. The number fell like a rock.

''We're just preparing for something a brain-injured person should not do two days out, which is travel to Germany,'' the neurologist said. He smiled grimly and started toward the UH–60 Black Hawk thwump-thwumping out on the helipad, waiting to spirit out of Iraq one more of the hundreds of Americans wounded here this month.

While attention remains riveted on the rising count of Americans killed in action—more than 100 so far in April—doctors at the main combat support hospital in Iraq are reeling from a stream of young soldiers with wounds so devastating that they probably would have been fatal in any previous war.

More and more in Iraq, combat surgeons say, the wounds involve severe damage to the head and eyes—injuries that leave soldiers brain damaged or blind, or both, and the doctors who see them first struggling against despair.

For months the gravest wounds have been caused by roadside bombs—improvised explosives that negate the protection of Kevlar helmets by blowing shrapnel and dirt upward into the face. In addition, firefights with guerrillas have surged recently, causing a sharp rise in gunshot wounds to the only vital area not protected by body armor.

The neurosurgeons at the 31st Combat Support Hospital measure the damage in the number of skulls they remove to get to the injured brain inside, a procedure known as a craniotomy. ''We've done more in 8 weeks than the previous neurosurgery team did in 8 months,'' Poffenbarger said. ''So there's been a change in the intensity level of the war.''

Numbers tell part of the story. So far in April, more than 900 soldiers and Marines have been wounded in Iraq, more than twice the number wounded in October, the previous high. With the tally still climbing, this month's injuries account for about a quarter of the 3,864 U.S. servicemen and women listed as wounded in action since the March 2003 invasion.

About half the wounded troops have suffered injuries light enough that they were able to return to duty after treatment, according to the Pentagon.

The others arrive on stretchers at the hospitals operated by the 31st CSH. ''These injuries,'' said Lt. Col. Stephen M. Smith, executive officer of the Baghdad facility, ''are horrific.''

By design, the Baghdad hospital sees the worst. Unlike its sister hospital on a sprawling air base located in Balad, north of the capital, the staff of 300 in Baghdad includes

the only ophthalmology and neurology surgical teams in Iraq, so if a victim has damage to the head, the medevac sets out for the facility here, located in the heavily fortified coalition headquarters known as the Green Zone.

Once there, doctors scramble. A patient might remain in the combat hospital for only six hours. The goal is lightning-swift, expert treatment, followed as quickly as possible by transfer to the military hospital in Landstuhl, Germany.

While waiting for what one senior officer wearily calls ''the flippin' helicopters,'' the Baghdad medical staff studies photos of wounds they used to see once or twice in a military campaign but now treat every day. And they struggle with the implications of a system that can move a wounded soldier from a booby-trapped roadside to an operating room in less than an hour.

''We're saving more people than should be saved, probably,'' Lt. Col. Robert Carroll said. ''We're saving severely injured people. Legs. Eyes. Part of the brain.''

Carroll, an eye surgeon from Waynesville, Mo., sat at his desk during a rare slow night last Wednesday and called up a digital photo on his laptop computer. The image was of a brain opened for surgery earlier that day, the skull neatly lifted away, most of the organ healthy and pink. But a thumb-sized section behind the ear was gray.

''See all that dark stuff? That's dead brain,'' he said. ''That ain't gonna regenerate. And that's not uncommon. That's really not uncommon. We do craniotomies on average, lately, of one a day.''

''We can save you,'' the surgeon said. ''You might not be what you were.''

Accurate statistics are not yet available on recovery from this new round of battlefield brain injuries, an obstacle that frustrates combat surgeons. But judging by medical literature and surgeons' experience with their own patients, ''three of four months from now 50 to 60 percent will be functional and doing things,'' said Maj. Richard Gullick.

''Functional,'' he said, means ''up and around, but with pretty significant disabilities,'' including paralysis.

The remaining 40 percent to 50 percent of patients include those whom the surgeons send to Europe, and on to the United States, with no prospect of regaining consciousness. The practice, subject to review after gathering feedback from families, assumes that loves ones will find value in holding the soldier's hand before confronting the decision to remove life support.

''I'm actually glad I'm here and not at home, tending to all the social issues with all these broken soldiers,'' Carroll said.

But the toll on the combat medical staff is itself acute, and unrelenting.

In a comprehensive Army survey of troop morale across Iraq, taken in September, the unit with the lowest spirits was the one that ran the combat hospitals until the 31st arrived in late January. The 3 months since then have been substantially more intense.

''We've all reached our saturation for drama trauma,'' said Maj. Greg Kidwell, head nurse in the emergency room.

On April 4, the hospital received 36 wounded in 4 hours. A U.S. patrol in Baghdad's Sadr City slum was ambushed at dusk, and the battle for the Shiite Muslim neighborhood lasted most of the night. The event qualified as a ''mass casualty,'' defined as more casualties than can be accommodated by the 10 trauma beds in the emergency room.

''I'd never really seen a 'mass cal' before April 4,'' said Lt. Col. John Xenos, an orthopedic surgeon from Fairfax. ''And it just kept coming and coming. I think that week we had three or four mass cals.''

The ambush heralded a wave of attacks by a Shiite militia across southern Iraq. The next morning, another front erupted when Marines cordoned off Fallujah, a restive, largely Sunni city west of Baghdad. The engagements there led to record casualties.

''Intellectually, you tell yourself you're prepared,'' said Gullick, from San Antonio. ''You do the reading. You study the slides. But being here. . . .'' His voice trailed off.

''It's just the sheer volume.''

In part, the surge in casualties reflects more frequent firefights after a year in which roadside bombings made up the bulk of attacks on U.S. forces. At the same time, insurgents began planting improvised explosive devices (IEDs) in what one officer called ''ridiculous numbers.''

The improvised bombs are extraordinarily destructive. Typically fashioned from artillery shells they may be packed with such debris as broken glass, nails, sometimes even gravel. They're detonated by remote control as a Humvee or truck passes by, and they explode upward.

To protect against the blasts, the U.S. military has wrapped many of its vehicles in armor. When Xenos, the orthopedist, treats limbs shredded by an IED blast, it is usually ''an elbow stuck out of a window, or an arm.''

Troops wear armor as well, providing protection that Gullick called ''orders of magnitude from what we've had before. But it just shifts the injury pattern from a lot of abdominal injuries to extremity and head and face wounds.''

The Army gunner whom Poffenbarger was preparing for the flight to Germany had his skull pierced by four 155mm shells, rigged to detonate one after another in what soldiers call a ''daisy chain.'' The shrapnel took a fortunate route through his brain, however, and ''when all is said and done, he should be independent. . . . He'll have speech, cognition, vision.''

On a nearby stretcher, Staff Sgt. Rene Fernandez struggled to see from eyes bruised nearly shut.

''We were clearing the area and an IED went off,'' he said, describing an incident outside the western city of Ramadi where his unit was patrolling on foot.

The Houston native counted himself lucky, escaping with a concussion and the temporary damage to his open, friendly face. Waiting for his own hop to the hospital plane headed north, he said what most soldiers tell surgeons: What he most wanted was to return to his unit.

Mr. STEVENS. I thank the Senator from Tennessee.

The PRESIDING OFFICER (Mr. SUNUNU). The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I ask unanimous consent to speak in morning business for as much time as I may require.

The PRESIDING OFFICER. The Senator has that right.

INTERNET TAXATION

Mr. ALEXANDER. Mr. President, I was just at a luncheon with the distinguished chairman of the Commerce Committee, and he wondered where I had been in terms of the debate on the Internet tax question. So here I am. I am glad to have this opportunity. I know we have been diverted to discuss the Energy bill. But I appreciate the leadership creating an opportunity to debate these issues.

As the Senator from New Hampshire knows, who is a member of the Commerce Committee, and has a large interest in the fastest-growing technology in America, the growth of high-speed Internet access—the question of how we approach, in a comprehensive way, the regulation and taxation of this new technology—is very important. It is important for our economic growth. It is important because, as we do this, we will be making, inevitably, major adjustments in terms of the responsibilities of State and local governments, and we need to do it right.

That is why I am encouraged by the fact Senator MCCAIN; Senator STEVENS; the Commerce Committee; Michael Powell, the Chairman of the Federal Communications Commission, all have announced that we need to take a new look at the Telecommunications Act of 1996 in light of the recent growth of high-speed Internet access.

I am not happy about the fact we are trying to solve problems that ought to be solved comprehensively, for the long term, on a piecemeal basis, which is exactly what some are trying to do, by turning a fairly innocuous idea—a temporary timeout on State and local taxation of Internet access; we are just talking about the connection between my computer and AOL or whoever is providing my Internet access; that is just a little bitty thing—they have turned that into a debate about whether we should give a broad exemption to the entire high-speed Internet access industry, and make decisions now about whether State and local governments will be able to continue to collect taxes on telephone services.

One of the problems with this debate is that everyone who stands up on opposite sides offers different facts and figures and interpretations, so a Member of the Senate who is not really studying or following this issue closely is easily misled.

Let me deal with four or five of the misconceptions. First, let me talk about what we are talking about. We are talking about high-speed Internet access, which was barely known to most Members of Congress when the 1996 Telecommunications Act was enacted, not very well known in 1998, when we all said—almost all of us said; I said this—let's take a temporary timeout. Let's not allow even State and local taxation of Internet access until we figure out what it is.

So we did that for 2 years. We did it then for 3 more years. Now the effort is to not just do that permanently but to just say: OK, this is a great new invention. Let's just exempt the whole industry from taxation.

High-speed Internet access is now offered in lots of different ways. The reason it is so important is because it means that lots of different services may come to my home. If I am watching television through direct satellite in my home here in the District of Columbia, there is a nice young woman who comes on and she advertises that