I again thank Reverend Longbottom for leading today's prayer for my colleagues and I in the U.S. Senate and for guiding us in reflecting upon the tremendous responsibilities we have as lawmakers.

COMMEMORATING THE 40TH ANNIVERSARY OF THE WILDERNESS ACT

Mr. FEINGOLD. Mr. President, as founder of the Senate Wilderness Caucus, I introduced a Senate resolution to commemorate the 40th anniversary of the Wilderness Act of 1964, which was signed into law on September 3, 1964, by President Lyndon B. Johnson. I thank the following colleagues for their support as cosponsors: Senator SUNUNU, Senator HAGEL, Senator DURBIN, Senator BOXER, Senator MCCAIN, Senator MURRAY, Senator LUGAR, Senator WARNER, Senator CHAFEE, Senator SNOWE, and Senator COLLINS.

The Wilderness Act became law seven years after the first wilderness bill was introduced by Senator Hubert H. Humphrey of Minnesota. The final bill, sponsored by Senator Clinton Anderson of New Mexico, passed the Senate by a vote of 73–12 on April 9, 1963, and passed the House of Representatives by a vote of 373–1 on July 30, 1964. The Wilderness Act of 1964 established a National Wilderness Preservation System ''to secure for the American people of present and future generations the benefits of an enduring resource of wilderness.'' The law gives Congress the authority to designate wilderness areas, and directs the Federal land management agencies to review the lands under their responsibility for their wilderness potential.

Under the Wilderness Act, wilderness is defined as ''an area of undeveloped federal land retaining its primeval character and influence which generally appears to have been affected primarily by the forces of nature, with the imprint of man's work substantially unnoticeable.'' The creation of a national wilderness system marked an innovation in the American conservation movement—wilderness would be a place where our ''management strategy'' would be to leave lands essentially undeveloped.

The original Wilderness Act established 9.1 million acres of Forest Service land in 54 wilderness areas. Now, after passage of 102 pieces of legislation, the wilderness system is comprised of over 104 million acres in 625 wilderness areas, across 44 States, and administered by four Federal agencies: the Forest Service in the U.S. Department of Agriculture, and the Bureau of Land Management, the Fish and Wildlife Service, and the National Park Service in the Department of the Interior.

As we in this body know well, the passage and enactment of the Wilderness Act was a remarkable accomplishment that required steady, bipartisan commitment, institutional support, and strong leadership. The U.S. Senate was instrumental in shaping this very important law, and this anniversary gives us the opportunity to recognize this role.

As a Senator from Wisconsin, I feel a special bond with this issue. The concept of wilderness is inextricably linked with Wisconsin. Wisconsin has produced great wilderness thinkers and leaders in the wilderness movement such as Senator Gaylord Nelson and the writer and conservationist Aldo Leopold, whose A Sand County Almanac helped to galvanize the environmental movement. Also notable is Sierra Club founder John Muir, whose birthday is the day before Earth Day. Wisconsin also produced Sigurd Olson, one of the founders of the Wilderness Society.

I am privileged to hold the Senate seat held by Gaylord Nelson, a man for whom I have the greatest admiration and respect. Though he is a well-known and widely respected former Senator and former two-term Governor of Wisconsin, and the founder of Earth Day, some may not be aware that he is currently devoting his time to the protection of wilderness by serving as a counselor to the Wilderness Society—an activity which is quite appropriate for someone who was also a co-sponsor, along with former Senator Proxmire, of the bill that became the Wilderness Act.

The testimony at congressional hearings and the discussion of the bill in the press of the day reveals Wisconsin's crucial role in the long and continuing American debate about our wild places, and in the development of the Wilderness Act. The names and ideas of John Muir, Sigurd Olson, and, especially, Aldo Leopold, appear time and time again in the legislative history.

Senator Clinton Anderson of New Mexico, chairman of what was then called the Committee on Interior and Insular Affairs, stated his support of the wilderness system was the direct result of discussions he had held almost 40 years before with Leopold, who was then in the Southwest with the Forest Service. It was Leopold who, while with the Forest Service, advocated the creation of a primitive area in the Gila National Forest in New Mexico in 1923. The Gila Primitive Area formally became part of the wilderness system when the Wilderness Act became law.

In a statement in favor of the Wilderness Act in the New York Times, then-Secretary of the Interior Stewart Udall discussed ecology and what he called ''a land ethic'' and referred to Leopold as the instigator of the modern wilderness movement. At a Senate hearing in 1961, David Brower of the Sierra Club went so far as to claim that ''no man who reads Leopold with an open mind will ever again, with a clear conscience, be able to step up and testify against the wilderness bill.'' For others, the ideas of Olson and Muir—particularly the idea that preserving wilderness is a way for us to better understand our country's history and the frontier experience—provided a justification for the wilderness system.

In closing, I would like to remind colleagues of the words of Aldo Leopold in his 1949 book, A Sand County Almanac. He said, ''The outstanding scientific discovery of the twentieth century is not the television, or radio, but rather the complexity of the land organism. Only those who know the most about it can appreciate how little is known about it.'' We still have much to learn, but this anniversary of the Wilderness Act reminds us how far we have come and how the commitment to public lands that the Senate and the Congress demonstrated 40 years ago continues to benefit all Americans.

COSPONSORSHIP OF S. 2603

Mr. BURNS. Mr. President, I am pleased to announce that I have signed on today as a cosponsor to S. 2603, the Junk Fax Prevention Act of 2004. This legislation is vital in preserving a valuable small business tool and empowers consumers by requiring an opt-out option on faxes.

Consumers will benefit from this act because of the provision that requires all unsolicited advertisers to provide an opt-out option on the front page of all solicitations. This notice must be clear and conspicuous, and the mechanism for opting out must be at no cost to the consumer.

The Junk Fax Prevention Act will also benefit small businesses because they will be able to continue corresponding with customers and business partners who have an established business relationship. This is especially important for businesses, like real estate companies and restaurants, which rely on faxes to do business. Faxes are beneficial because they are a low cost way to stay in touch with customers and clients. When an employee leaves a business, his or her email account is frequently shut down. Faxes allow the information to reach the new person with the correct job.

Communication is the key to successful businesses. This bill strikes the right balance between prohibiting unwanted faxes while allowing small businesses to easily stay in touch with customers.

I thank my colleague from Oregon, Senator SMITH, for sponsoring this legislation. I look forward to discussing the Junk Fax Prevention Act of 2004 in committee and urge my colleagues to adopt the necessary pro-small business and pro-consumer legislation.

THE GLOBAL FIGHT AGAINST AIDS

Mr. HARKIN. Mr. President, on July 11, the 15th Annual International AIDS Conference began in Bangkok, Thailand. The theme of this year's conference is ''Access for All,'' meaning access to lifesaving medications. As

many of my colleagues know, the current AIDS pandemic threatens approximately 38 million people worldwide. Last year, 5 million more became infected. Sixty percent of all cases are in sub-Saharan Africa, but the virus is spreading almost unchecked in Asia and Eastern Europe. Twenty million people world-wide have died since the first case was diagnosed in 1981.

Unfortunately, the theme of the Bangkok conference—''Access for All''—is a hope and aspiration that bears little resemblance to the harsh reality we confront today. In reality, most newly infected people will not receive anti-retroviral drugs in time to do any good.

There are many barriers to progress: developing countries lack the trained physicians, nurses, or support staff to properly distribute anti-retroviral drugs and to monitor patients' progress. In addition, contributions to the Global Fund to Fight AIDS are not sufficient. Some countries are falling far short of what is needed.

And on July 1, the Wall Street Journal reported another big reason why drug distribution has been difficult. Simply put, the United States government will not purchase effective generic drugs; it insists on brand-name pharmaceuticals. Let me give you an example of why this matters.

On April 6, The Washington Post reported on pricing agreements negotiated by the William Jefferson Clinton Foundation with pharmaceutical companies that produce generic drugs. These agreements, in cooperation with the Global Fund, the World Bank, and UNICEF, will provide access to affordable AIDS drugs in 100 developing nations around the world. As a result, as many as 3 million additional people will be tested and treated for AIDS than before.

Under negotiated pricing agreements with five generic-drug companies—four in India and one in South Africa—the Foundation will reduce the cost of fixed-dose generic AIDS drugs by as much as half. Fixed-dosage drugs combine several drugs in one pill. This makes the treatments simpler to take. Research tells us that simplified treatment programs have more successful outcomes. The cost to test and treat a patient will drop from more than $500 per year down to $200 per year. The drugs themselves will cost only $140 per person, per year.

These are significant savings. And the savings have positive results. More people can be tested and treated than with existing programs. This is progress. These negotiated agreements will save lives.

In his 2003 State of the Union Address, President Bush announced a $15 billion plan to combat HIV/AIDS worldwide. Certainly, this was an admirable initiative. Authorizing legislation passed overwhelmingly in the House and Senate.

But, the administration has taken a different approach in implementing this plan than the Clinton Foundation has with their negotiated pricing agreements. I am concerned the $15 billion AIDS policy the President is pursuing is not nearly as effective as these negotiated agreements. Why? Because instead of negotiating for the most effective drugs for the lowest cost, the administration purchases brand-name pharmaceuticals from western countries at twice the cost.

For example, at a hospital in Zimbabwe, the Centers for Disease Control will soon implement a program that calls for patients to take six pills per day, from a variety of brand-name manufacturers, at a cost of $562 per patient, per year. Yet at the very same hospital, using the very same procedures, Doctors Without Borders purchases fixed-dosage retroviral drugs —two pills per day—from an Indian generic manufacturer. The treatment program costs $244 per patient per year—$318 less than the price the CDC pays. The programs have the same goals, at the same hospital, but the program sponsored by the U.S. Government costs more than twice as much.

This is not the most effective use of taxpayer money. The administration could use fixed-dosage, generic drugs, but won't. Instead it chooses to purchase multiple brand-name drugs, and implement a more complicated treatment regimen at more than twice the price. If the goal is to treat the AIDS epidemic, then why are we spending twice-as-much money on more complicated, less effective treatment? Where is the outrage about waste, fraud, and abuse in the Federal Government—not to mention plain old-fashioned stupidity?

Unfortunately, the answer is all too familiar. The administration has chosen to side with the brand-name pharmaceutical industry— despite the cost, and despite the efficacy. We have seen this behavior before.

This brings us back to the Clinton Foundation's negotiated agreements with generic firms. My colleagues will be interested to know the man in charge of the Bush administration's AIDS initiative is Eli Lilly's former Chief Executive Officer, Randall Tobias. Recently, Mr. Tobias told Congress he had doubts about the quality of cheaper generic AIDS drugs made in India—the same drugs which the Clinton Foundation negotiated the pricing agreements. But, the World Health Organization approved the drugs and has an approval process similar to our own Food and Drug Administration. In fact, WHO's approval process was borrowed from the FDA. In testimony before the Senate Foreign Relations Committee on April 7, Dr. LuLu Oguda of Doctors Without Borders stated that she was ''bewildered by the debate'' about the use of generic fixed-dosage drugs to combat AIDS in Africa. She noted that the generics used were not ''substandard'' as claimed by the Bush Administration. Rather, they were made in some of the same facilities as generic drugs sold every day in the United States. As a volunteer in Malawi, a country where one fifth of the population lives with HIV, she knows the value of these quality generics.

I am left to conclude that the Bush administration has made a conscious choice. Cheaper, effective drugs are put aside in order to purchase more complex treatments from domestic pharmaceutical manufacturers. Fewer HIV/AIDS patients are treated, and more inefficiently. This is no different than refusing to support negotiation authority for Medicare beneficiaries. Fewer drugs can be purchased because prices remain high.

Beyond the burden to taxpayers, these policies have grave human consequences. People's lives are at stake. Prescription drugs are not like other consumer products. They are not optional or discretionary. For people with HIV/AIDS, lack of access to drugs can mean debilitating illness and even death. It's not like buying a car—the customer can't walk away from the deal with his or her health in tact. So the choices that we make here in Washington, the choices that the pharmaceutical industry makes, are fateful choices. And let's be clear, the pricing practices favored by the administration and the pharmaceutical industry will cost countless lives in Africa and here at home.

I fully appreciate the need to preserve the pharmaceutical industry's ability to perform research and development. The Federal Government already supports this through rich tax incentives. Likewise, I certainly do not dispute the industry's right to make a profit. But we are quickly coming to the point where the pursuit of reasonable profits turns into flat out profiteering. Diseases are viewed as marketing opportunities, not as scourges to be eliminated as rapidly and as cost-effectively as possible.

There is no question in my mind that we need to reopen the issue of how we negotiate drug prices in the program to combat HIV/AIDS worldwide. If we take the Clinton Foundation's approach, we can reach roughly twice as many patients. It is also time for us to reopen the issue of negotiations with pharmaceutical companies in our own country. It is time for our choices to put people ahead of profits.

I ask unanimous consent that an article from this morning's Washington Post and a transcript of a recent radio program on the International AIDS Conference in Bangkok be printed in the RECORD.

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

[From the Washington Post, July 14, 2003]

U.S. RULE ON AIDS DRUGS CRITICIZED

(By Ellen Nakashima and David Brown)

BANGKOK, July 13.—The Bush administration's prohibition against using money from its $15 billion global AIDS plan to buy foreign-produced generic drugs is complicating

the delivery of medicine to some of the millions of poor people who badly need it, according to AIDS experts at an international conference here.

In an effort to sidestep the policy, some countries have been using U.S. money to train AIDS clinicians and buy lab equipment, while employing money from other sources to buy the medicines.

U.S. officials at the conference said Tuesday that they would go along with such an approach. They have also said a fast-track plan announced in May would allow some of the generics to receive rapid approval from the Food and Drug Administration, which would make them eligible for U.S. funding.

Specified in the giant President's Emergency Plan for AIDS Relief, the restrictions against unapproved generics, which for now include all foreign-made generics, have added to the already long list of obstacles to bringing antiretroviral (ARV) therapy to poor countries, experts attending the 15th International AIDS Conference here say.

''It was very confusing. You're trying to figure out who can buy what with what money,'' said Joia Mukherjee, medical director for Partners in Health, a Boston-based organization that has run an AIDS treatment program in Haiti for seven years and is developing others in Latin America.

The policy ''slows the coordination'' between the Bush plan and the people running treatment programs in the countries, Mukherjee said in an interview at the conference.

The U.S. Government Accountability Office reached similar conclusions in a report issued this week.

The GAO interviewed 28 U.S. government employees involved in the plan in the 15 countries where it is starting to operate. ''Twenty-one respondents indicated that they had not received adequate guidance on the procurement of ARV drugs, which makes it difficult for the U.S. missions'' to support country programs.

The State Department, which runs the plan, has not specified which activities the program ''can fund and support in national treatment programs that use ARV drugs not approved for purchase by the office,'' the authors wrote.

Partners in Health is expecting to receive at least $1 million in fiscal 2005 from the U.S. program. Mukherjee said she first began about nine months ago to inquire about whether it could be used to buy generic drugs. She—and others—were told no several months ago. But last week, she said, she was advised unofficially to use money from another source to buy generics and use the U.S. money for such things as salaries for health care workers, lab tests and a van.

That was ''a compromise that wasn't acceptable before,'' said a person affiliated with one of the organizations that received a large Bush administration AIDS grant last winter. ''We're still in the process of working out what drugs we will buy . . . in the countries we're in,'' said the official, who spoke on condition of anonymity.

Randall L. Tobias, the Bush administration's global AIDS coordinator, officially ratified that view in a statement Tuesday.

''We respect local governments' decisions as to how best to manage their HIV/AIDS programs,'' he said. ''We will, however, not use U.S. tax dollars to purchase medications that have not passed the same consumer protection standards as those we use for our own patients in the United States.

''In the event that a country elects to use non-U.S. funding to purchase copy drugs that have not been approved for quality and safety by the U.S., the president's emergency plan will support non-pharmaceutical aspects of the country's care, treatment and prevention programs, and will do whatever is necessary to maintain integrated systems of care.''

AIDS treatment that uses generic pills containing three antiretroviral drugs in one tablet—known as fixed-dose combinations—can cost as little as $200 a year. That is less than half the cut rates at which major pharmaceutical companies are offering brand-name drugs in poor countries.

Most organizations that are providing money for AIDS drugs in those countries—notably, the two-year old Global Fund to Fight AIDS, Tuberculosis and Malaria—require that generics they purchase go through a process called pre-qualification that is run by the World Health Organization and is similar to FDA approval.

The U.S. program does not recognize prequalification and instead has specified that all drugs it pays for must be approved by the FDA. In May, the agency established a fast-track system by which it will rule on applications from generics makers in two to six weeks.

Anthony S. Fauci, the physician and AIDS researcher who heads the National Institute of Allergy and Infectious Diseases, acknowledged the controversy over generics at a news conference Tuesday.

''I know there's been criticism about that, but I think we should give a chance to the FDA to prove if they're able to do it or not,'' he said. ''The only way to do that . . . is to submit the application for the approval process.''

Progress in the effort to put 3 million poor AIDS patients on treatment by the end of next year has been a major topic of discussion at the conference, whose theme is ''Access for All.''

In Haiti, where 280,000 people are living with HIV, the virus that causes AIDS, Partners in Health had about 50 patients on antiretroviral drugs in 2001. Today, largely with Global Fund money, it is treating 1,500. The drugs are administered free through a community health clinic.

Cissy Kityo of the Joint Clinical Research Center in Uganda said that country's government cannot afford to pay for all the drugs it is providing patients, even with a price of about $300 per person per year for generics. Consequently, about 90 percent of the 20,000 people on treatment are paying for their drugs, she said.

Uganda's policy of making people pay for their drugs has allowed it to spend funds instead to hire and train health care workers, who are critical to prevention and treatment efforts, Kityo said. ''We're just a small country trying to do our best,'' she said.

Chief among nongovernmental organizations providing antiretroviral drugs is Medecins Sans Frontieres, whose name in English is Doctors Without Borders. Today it has 13,000 patients in 56 projects in 25 countries in Africa, Asia, Eastern Europe and Latin America. About half are on fixed-dose combinations, which spokeswoman Rachel Cohen termed a ''radically simplified'' treatment.

The organization is spending $200 per person per year. The best available price worldwide for brand-name equivalents is $562 per person per year. ''If you have the option of spending $200 per person per year or $600 per person per year, and you're electing to spend $600, that means you're treating one person when you could be treating three,'' Cohen said.

[From NPR News Morning Edition, July 13, 2004]

ANALYSIS: SMALL INDIAN FIRM CIPLA MANUFACTURES LOW-COST GENERIC AIDS DRUGS, BUT ITS PRODUCTS FACE BANS IN MANY COUNTRIES

STEVE INSKEEP (host). This is Morning Edition from NPR News. I'm Steve Inskeep.

RENEE MONTAGNE (host). And I'm Renee Montagne.

At this year's International AIDS Conference in Bangkok, most of the talk is about getting inexpensive, generic drugs to tens of millions of people. Relatively small generic drug manufacturers in four countries are at the center of the debate. One of the more aggressive of these companies is the Indian firm Cipla. In India, where five million people are infected, Cipla had trouble persuading the previous government to spend money on AIDS, even for generic drugs that cost pennies a day. NPR's Brenda Wilson recently visited Cipla.

BRENDA WILSON (reporting). Once inside Cipla's corporate headquarters in Mumbai, also known as Bombay, you're whisked off to a large room. It is surrounded on three sides by a glass wall of backlit shelves containing hundreds of samples of the company's products. You're then shown a six-minute promotional video that recounts Cipla's founding 70 years ago.

UNIDENTIFIED WOMAN NO. 1. To heal and to hold, to wipe a tear, bring back a smile, to give hope, to give life. That's been Cipla's mission right from the time it started way back in 1935.

Mr. AMAR LULLA (managing co-director, Cipla). Welcome to Cipla.

WILSON. Good meeting you, Mr. Lulla.

Mr. LULLA. Good to see you.

WILSON. That's Amar Lulla?

Mr. LULLA. That's me.

WILSON. OK, Amar.

Mr. LULLA. Yeah.

WILSON. So you are—what's your title exactly?

Mr. LULLA. I'm the joint managing director. I want you to see the range of products that we do here. We have over 1,200 products, exporting to 150 countries. We first start here. This is the range of our anti-infectives, antibacterials, quinolones, microlites . . .

WILSON. Some of them, products that have been approved by the U.S. Food and Drug Administration and are sold in the U.S. Indian drugmakers, not just Cipla, have been something of a thorn in the side of the big pharmaceutical companies, who see generic versions of their brand-name products as virtual rip-offs of intellectual property. They argue that the companies that make generics have not put the billions of dollars into research to develop drugs, just copied them. They also say that the copies are not always safe and may not have the same benefits.

Mr. LULLA. Here is the range of AIDS drugs. This is what we're a little bit known for, if I may say so. And now we're offering the triple-drug cocktail for less than 50 cents a day now.

WILSON. And that's this drug right here.

Mr. LULLA. This drug.

WILSON. Triomune, yes.

Mr. LULLA. Triomune. That is a combination of lamivudine, stavudine and nevirapine.

WILSON. All three in one pill, which means it's not only cheaper but easier to take. It is this product more than any other that holds up the hope of treating millions of people in poor countries who have AIDS. The patents for the drugs are held by three different manufacturers who, until recently, could not agree to share and therefore combine the compound in one pill.

UNIDENTIFIED WOMAN No. 2. (Foreign language spoken.)

WILSON. The Y.R. Gaitonde Center, an AIDS clinic in the southern city of Chennai, which treats more than 5,000 HIV patients, is one of the few places where reduced-price drugs are available in India. Oddly enough, Cipla sells most of its AIDS drugs to other countries. Today patients have lined up outside the pharmacy to purchase medications.

A pharmacist gives a gaunt young man his change and explains just when and how to take the medicine. Patients pay what they can. They're required to pay something. It's a way of making sure that the patient wants to be part of the program and will follow treatment regimens carefully. The YRG Center gets a special discount, and Cipla assists in other ways. Lulla says it's been trying for years to sell more generic AIDS drugs in India, but the government has not until recently agreed to Cipla's terms. But Amar Lulla insists that the company's motive isn't money and it isn't publicity.

Mr. LULLA. If you've seen the face of disease and if you've seen the face of death and if you've seen people dying because they can't access medicines, and if you save one life, it is worth it. To some of us, it's very important, you know. And then I can see a lot of cynicism in the media and in the way people do ask us, what is behind all this, you know? What is the motive? What is the motive? But sometimes doing this is an immense joy and serves the need that we all have within us as human beings, you know, to help someone. That's it. There's nothing more to it.

WILSON. Still, nowhere near the two million people in India that it is estimated now need treatment get it. Vivek Divan with the Lawyers Collective AIDS Unit says it's a profound paradox.

Mr. VIVEK DIVAN (Lawyers Collective AIDS Unit). A lot of our clients are dying. They just continue to die. It's a ridiculous situation. It's absurd because, you know, Cipla and Ranbaxy make this medication in this country, and it wasn't available and still isn't more or less available. When you think about it, it is such an absurd situation, it's so starkly absurd that it shocks you sometimes. It makes you laugh also, unfortunately.

WILSON. Late last year the Indian government finally struck a deal with Cipla, and in April, just before the national elections, the government began distributing free antiretrovirals for people with AIDS.

Ms. MEENAKSHI DATTA GHOSH (Director, National AIDS Control Organization). We have treated more than 800 people so far, and we do want to very rapidly accelerate the treatment.

WILSON. Meenakshi Datta Ghosh is the director of the government's National AIDS Control Organization.

Ms. DATTA GHOSH. We have trained teams in 25 medical hospitals, and that's where we are now moving to expand. And so we do believe the numbers getting treated will rapidly pick up.

WILSON. 'Cause 800, you know, for a population this size, seems incredibly small.

Ms. DATTA GHOSH. That's very unfair. We've only been in the treatment less than four months. Since May 2003 onwards, we have concentrated on expanding and widening the availability of services for people living with HIV and for the general population. Political commitment for HIV and AIDS has grown by leaps and bounds. All of this put together has enabled us to commence treatment earlier than perhaps was originally scheduled. And therefore, I do not—it's not entirely correct to say the government has not done anything.

WILSON. By the end of this year, she says, the government aims to provide treatment for 100,000 AIDS patients. India is not alone in the caution with which it has taken on treatment, using the generic AIDS drugs. Scientists and health officials question Cipla's capacity to supply generic drugs to the millions in developing countries who need them and maintain that supply for the rest of their lives. There are also concerns that generics may contribute to the development of a more resistant AIDS virus. Again, Cipla's Amar Lulla.

Mr. LULLA. This is such a beautiful argument, such a beautiful one when you don't want the drugs to reach the dying patients. The big pharmacy will say this argument is never advanced. Why? The same drugs, the same side effects, the same risk of developing resistance. Why is it not talked about? Why is it talked about only when you want to make them available to the patients, and you talk all this junk, I mean, such rubbish, it's not even pardonable. So don't give to anybody, right? If you can't give to 40 million, don't give to one million. Don't make these drug available to anybody. Let everybody die. What kind of argument is this? And this is such a con, such a lie, it's a crime on humanity, and everybody repeats it, you know. That's a pity.

WILSON. Some of the suspicions about generics and the quality of Cipla's three-in-one pill Triomune were answered by a recent study that was published in the British journal Lancet. As doctors had already noted, Tromune was just as effective at suppressing the AIDS virus as brand-name medications. Brenda Wilson, NPR News.

MONTAGNE. It's 11 minutes before the hour.

ADDITIONAL STATEMENTS

TRIBUTE TO JOHN A. FORLINES JR.

● Mrs. DOLE. Mr. President, I rise to salute a true gentleman who has just announced his retirement from the position of Chairman and CEO of the Bank of Granite based in Granite Falls, NC: Mr. John A. Forlines Jr. John is a man of great integrity and ability.

John's bank has become legendary, as it is often called ''the best little bank in America.'' However, his achievements extend beyond his professional life, for he is also well known for an outstanding history of service to his community, state and his country.

I had the pleasure of serving with John as a trustee for Duke University, and I was continually impressed with his intelligence, his dedication and his great enthusiasm for Duke University and higher education. A native of Graham, NC and a graduate of Duke, John joined the U.S. Army finance department in 1940, and eventually rose to the rank of Major.

John's extraordinary career with the Bank of Granite began in 1954, when he assumed the position of President. Soon after, he was named chairman of the North Carolina School of Banking at the University of North Carolina-Chapel Hill, and began his lifelong relationship with the American Bankers Association. He was later named Chairman of the North Carolina Banking Association. John's work has resulted in the continued growth of stronger communities across North Carolina. Through his work he has provided the capital for many businesses to be established and grow, creating good jobs. He work also financed countless homes for families and individuals across the state.

In addition, John has furthered his commitment to the communities of North Carolina through his dedication to service in his personal life. He serves on the Board of Elders of First Presbyterian Church in Lenoir, NC. He also holds positions on the Board of Directors for the North Carolina Citizens for Business and Industry; Caldwell County Hospice Inc.; Piedmont Venture Partners; and The Forest at Duke, a retirement community.

John's dedication to his profession and community has been recognized through the years with numerous honors and distinctions. These accolades include Financial World Magazine CEO of the Year for banks $300–$500 million in assets from 1992 to 1995. He received Duke University's Distinguished Alumni Award in 1994; and was inducted into the North Carolina Business Hall of Fame in 1999.

John Forlines epitomizes the American spirit through his entrepreneurial skills and his ever present commitment to family and community. He serves as an inspiration to us all. I appreciate his warm friendship and his tremendous service on behalf of all North Carolinians.●

RECOGNITION OF DR. ROBERT K. STUART

● Mr. HOLLINGS. Mr. President, I wish to recognize and congratulate Dr. Robert K. Stuart for his accomplishments in the fight against cancer. He is a long-time leader in the medical cancer community on a professional and personal level. For his devotion to make a difference in the lives of others, Dr. Stuart deserves to be honored. He has fought cancer on many levels and is a model of inspiration to his community.

I ask that a recent Post and Courier article be printed in the RECORD, so that all my colleagues can see the extraordinary accomplishments of this man.

The material follows:

[From the Post and Courier, July 10, 2004]

CANCER DOCTOR, SURVIVOR TO JOIN LANCE ARMSTRONG ON TOUR

(By David Quick)

Cancer survival and cycling were forever linked when Texan Lance Armstrong survived testicular cancer and won not one, but five consecutive—and perhaps six—Tour de France races.

But long before Armstrong would become a household name, oncologist Dr. Robert K. Stuart was in the trenches fighting the war on one of humankind's most deadly diseases and using cycling as an escape and a way to stay strong physically and emotionally.

This October, the worlds of Armstrong and Stuart will come together for a week during the Bristol-Myers Squibb Tour of Hope, a 3,200-plus-mile relay from Los Angeles to Washington, DC. Stuart is one of 20 cyclists selected to participate in the tour from among more than 1,000 applicants.

Besides riding four hours every day, Stuart and the other cyclists, along with Armstrong, will be making stops along the way, spreading the message of hope and encouraging cancer patients to participate in new treatments, often referred to as clinical trials.

Stuart certainly has earned the honor.