The Commission transmitted its determination in this investigation to the Secretary of Commerce on September 4, 1990. The views of the Commission are contained in USITC Publication 2311 (September 1990), entitled "High-Information Content Flat Panel Displays and Subassemblies Thereof from Japan: Determination of the Commission in Investigation No. 731–TA–469 (Preliminary) Under the Tariff Act of 1930, Together With the Information Obtained in the Investigation."

By order of the Commission.

Issued: September 7, 1990.

Kenneth R. Mason,

Secretary.

[FR Doc. 90–21398 Filed 9–11–90; 8:45 am]

BILLING CODE 7020–02–M

[Investigation No. 731–TA–445 (Final)]

Industrial Nitrocellulose From Yugoslavia

AGENCY: United States International Trade Commission.

ACTION: Revised schedule for the subject investigation.

EFFECTIVE DATE: August 27, 1990.

FOR FURTHER INFORMATION CONTACT: Tedford Briggs (202–252–1181), Office of Investigations, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436. Hearing-impaired individuals may obtain information on this matter by contacting the Commission's TDD terminal on 202–252–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–252–1000.

SUPPLEMENTARY INFORMATION: Effective April 19, 1990, the Commission instituted the subject investigation and established a schedule for its conduct (55 FR 19367, May 9, 1990). The Commission held a public hearing in Washington, DC on May 29, 1990. Subsequent to the Commission's hearing, the Department of Commerce extended the date for its final less than fair value (LTFV) determination in the investigation from July 2, 1990, to September 6, 1990, and the Commission revised its schedule in the investigation to conform with Commerce's new schedule (55 FR 30284, July 25, 1990). Commerce subsequently made its final LTFV determination on August 27, 1990 (55 FR 34946). The applicable statute directs that the Commission make its final injury determination within 45 days after Commerce's final LTFV determination, or in this case by October 10, 1990.

Therefore, the Commission's new schedule for the investigation is as follows: The deadline for filing posthearing briefs is September 18, 1990. and the deadline for Parties to file additional written comments on business proprietary information is September 24, 1990.

For further information concerning this investigation see the Commission's notice of investigation cited above and the Commission's Rules of Practice and Procedure, part 207, subparts A and C (19 CFR Part 207), and part 201, subparts A through E (19 CFR part 201).

Authority: This investigation is being conducted under authority of the Tariff Act of 1930, title VII. This notice is published pursuant to § 207.20 of the Commission's rules (19 CFR 207.20).

By order of the Commission.

Kenneth R. Mason,

Secretary.

Issued: September 4, 1990.

[FR Doc. 90–21399 Filed 9–11–90; 8:45 am]

BILLING CODE 7020–02–M

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Jose Bruno Armijo, M.D., Revocation of Registration

On December 1, 1989, the Deputy Assistant Administrator of the Drug Enforcement Administration (DEA) issued an Order to Show Cause to Jose Bruno Armijo, M.D., 1331 San Andreas Avenue NW., Albuquerque, New Mexico 87197, proposing to revoke his DEA Certificate of Registration, AA2840418, and to deny any pending applications for renewal of that registration as a practictioner under 21 U.S.C. 823(f). The statutory predicate for the Order to Show Cause was Dr. Armijo's lack of authorization to engage in the manufacturing, distribution, or dispensing of controlled substances in the State of New Mexico.

The Order to Show Cause was sent by registered mail to Dr. Armijo at his personal residence, which was also the address listed on his DEA Certificate of Registration. Dr. Armijo received notice of the registered mail on December 11 and 16, 1989. It was returned to the DEA on December 21, 1989, as unclaimed. On January 25, 1990, a DEA Special Agent attemptd to serve the Order to Show Cause at Dr. Armijo's residence, but he did not appear to be there. On January 26, 1990, a DEA Investigator was informed by the local postal representative that Dr. Armijo continued to receive and accept mail at his registered location. An attempt by DEA to serve the Order to Show Cause that same day was unsuccessful. On January 31, 1990, a DEA Investigator again attempted to serve the Order to Show Cause at Dr. Armijo's residence after he was seen there earlier that day. The attempt was fruitless. Similarly, a DEA Investigator's attempts to serve the Order to Show Cause on February 14 and 20, 1990, and a Special Agent's attempts to so serve Dr. Armijo on three separate occasions in March of 1990, were unsuccessful. During this time period, Dr. Armijo's employment status was, and remains, unknown. He vacated his office several months before the Order to Show Cause was initially sent to his residence via registered mail.

It is quite evident that Respondent has been resisting all attempts by DEA to serve him with the Order to Show Cause. Considerable effort has been made to serve the Order to Show Cause without success. Further attempts to notify Dr. Armijo of these proceedings and to offer him an opportunity to participate would be pointless. Consequently, the Administrator now enters his final order in this matter based upon the investigative file.

The Administrator finds that on August 11, 1988, the Board of Medical Examiners of the State of New Mexico (Board) suspended Respondent's state license based on his inability to practice medicine with reasonable skill and safety due to excessive use or abuse of alcohol or drugs. The Board relied, in part, on a prescription survey conducted by the New Mexico Board of Pharmacy which indicated that Dr. Armijo was over-prescribing Dilaudid, a Schedule II narcotic controlled substance. The Board scheduled an examinatioan and hearing to discuss the results of the survey with him and to determine whether the habitual use or abuse of drugs or alcohol was affecting his ability to practice medicine. Dr. Armijo failed to appear, claiming that he was out of state the day of the hearing. It was subsequently determined, however, that he wrote prescriptions for controlled substances on the very day the hearing had been scheduled. The Board then suspended his state license.

On September 21, 1988, a DEA Investigator and a State Inspector visited Dr. Armijo at his residence, and asked him to voluntary surrender his DEA Certificate of Registration and his state controlled substances registration based upon the action of the Board. Dr. Armijo refused. By letter dated October 4, 1988, and sent by certified mail, the DEA again asked Dr. Armijo to voluntarily surrender his registration. The DEA never received the return

receipt. A second letter dated January 6, 1989, and sent via certified mail, was returned to DEA as unclaimed. On March 3, 1989, a DEA Investigator and a State Inspector returned to Dr. Armijo's residence and, after knocking on the front door several times, placed a copy of the January 6, 1989 letter with a voluntary surrender form in an envelope addressed to Dr. Armijo in the locked outer door of the residence. No response has ever been recieved.

On June 30, 1989, the Board of Medical Examiners of New Mexico revoked Respondent's state license based on a finding that Dr. Armijo prescribed controlled substances on 107 separate occasions to individuals for no legitimate medical purpose. Since Dr. Armijo failed to request a hearing on the matter and did not rebut the alligations against him, the Board's decision is final and is not subject to judicial review.

The Board's action has terminated Dr. Armijo's authority to possess, prescribe, administer, dispense or otherwise handle controlled substances in the State of New Mexico. DEA does not have the statutory authority under the Controlled Substances Act to issue or maintain a registration if the applicant or registrant lacks state authority to manufacture, distribute dispense or otherwise handle controlled substances. *See* 21. U.S.C. 823(f). *See also Howard J. Reuben, M.D.*, 52 FR 8375 (1987); *Ramon Pla, M.D.*, 51 FR 41168 (1986); *Dale D. Shahon, D.D.S.*, 51 FR 23481 (1986); and cases cited therein. The Administrator therefore concluded that Dr. Armijo's Certificate of Registration should be revoked due to his lack of authority to handle controlled substances in the State of New Mexico.

Accordingly, the Administrator of the Drug Enforcement Administration, pursuant to the authority vested in him by 21 U.S.C. 823 and 824 and 28 CFR 0.100(b), hereby orders that DEA Certificate of Registration, AA2840418, previously issued to Jose Bruno Armijo, M.D., be, and it is hereby, revoked. It is further ordered that any pending applications for renewal of that registration be, and they are hereby, denied.

This order is effective September 12, 1990.

Dated: August 31, 1990.

Robert G. Bonner,

Administrator.

[FR Doc. 90-21305 Filed 9-11-90; 8:45 am]

BILLING CODE 4410-09-M

Pompeyo Q. Braga Bonado, M.D., Denial of Application

On May 7, 1990, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration (DEA) issued an Order to Show Cause to Pompeyo Q. Braga Bonado, M.D. (Respondent) proposing to deny his application, executed on November 22, 1988, for registration as a practitioner under 21 U.S.C. 823(f). The Order to Show Cause alleged that Respondent's registration would be inconsistent with the public interest.

Respondent,through counsel, waived his opportunity for a hearing and instead, filed a written statement on the issues raised by the Order to Show Cause pursuant to 21 CFR 1301.54(c). The Administrator has considered the investigative file, as well as Respondent's written statement, and hereby enters his final order in this matter based upon findings of fact and conclusions of law as hereinafter set forth.

In March 1987, the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Board of Medical Examiners (hereinafter referred to as Board) received information that Respondent was indiscriminately prescribing large quantities of Schedule II controlled substances for suspicious individuals. As a result, the Board's Drug Diversion Section initiated an undercover investigation.

On April 10, 1987, a Board investigator went to Respondent's office in an undercover capacity. Respondent took a medical history from the investigator and performed a cursory physical examination. The investigator requested that Respondent provide her with a prescription for Doriden, a Schedule III controlled substance, expressly advising Respondent that she did not have trouble sleeping, but rather wanted the Doriden because it made her feel good. Respondent advised the investigator that he needed a medical reason for prescribing the medication. The investigator then observed Respondent writing on her medical record "difficulty sleeping." Respondent issued the investigator a prescription for 30 Doriden tablets. The investigator paid Respondent $35.00.

On April 16, 1987, the undercover investigator returned to Respondent's office. On this occasion, Respondent took the investigator's blood pressure, but performed no other physical examination. The investigator requested that Respondent provide her with a prescription for Dilaudid, a Schedule II controlled substance. Although Respondent declined to prescribe Dilaudid, he issued the investigator a prescription for 30 tablets of Doriden. Respondent then asked the investigator if she wanted anything else. Upon her request, Respondent issued the investigator a prescription for 15 tablets of Tylenol with codeine #3. The investigator paid Respondent $30.00. The combination of Doriden and Tylenol with codeine is popular with street abusers as a heroin substitute.

On June 4, 1987, the investigator returned to Respondent's office. Although Respondent declined to prescribe the investigator Doriden, codeine, Dilaudid or Tylox, he did issue the investigator a prescription for 30 tablets of Percodan, a Schedule II narcotic controlled substance. Respondent stated that he needed to justify the prescription by indicating in her medical record that she was in pain, knowing that the investigator had not presented symtoms of pain. Respondent refused to provide the investigator with a prescription for Doriden in her "husband's" name, advising the investigator to see another physician and alternate between the two in order to obtain more prescriptions. Respondent did not conduct any sort of physical examination on this occasion, nor did he discuss any medical problems with the investigator. The investigator paid Respondent $30.00.

The investigator returned to Respondent's office on June 22, 1987. Respondent refused to prescribe Dilaudid or codeine base products, however, he issued the investigator a prescription for Doriden. Respondent did not perform any sort of physical examination nor did he ask any medial questions. The investigator paid Respondent $30.00.

A different Board investigator went to Respondent's office in an undercover capacity on April 10, 1987. Respondent took a medical history from the investigator. The investigator requested that Respondent provide her with a prescription for Percocet, advising him that although she did not know why she started taking it more than one year before, she needed it. The investigator advised Respondent that she was not in pain. Respondent stated that he needed a reason to give the investigator the Percocet. Notwithstanding the investigator's statement that she was not in pain, Respondent stated that he would diagnose her problem as migraines. Respondent then performed a cursory physical examination and gave her a prescription for 30 tablets of Darvocet-N. The investigator paid Respondent $35.00.

On April 25, 1987, the second investigator returned to Respondent's office. After advising Respondent that the Darvocet-N which he had previously prescribed was "no good," the investigator asked for a prescription for Percocet. Respondent advised the investigator that she would have to undergo a test to "cover" themselves, so they would not "go to jail" if she wanted him to "keep giving (her) Percocet." Nonetheless, Respondent issued the investigator a prescription for 30 tablets of Percocet on this occasion. Although Respondent took the investigator's blood pressure, he did not perform any other physical examination. The investigator paid Respondent $30.00.

The Administrator concludes that none of the prescriptions issued for the two Board investigators were issued for a legitmate medical purpose nor in the course of professional practice.

During the course of the investigation, Board investigators learned of an individual who was seen by Respondent at his office between November 1986 and May 1987. When the individual first visited Respondent, he complained of back pain. Respondent took his temperature and blood pressure, but performed no additional physical examination. Respondent then issued the individual a prescription for 30 tablets of Percocet. The individual returned to Respondent's office a month later and received another prescription for Percocet, "with no question asked with regards to my health." Thereafter, he returned to Respondent's office two to three times each week. On each visit Respondent gave the individual a prescription for 30 tablets of Percocet without performing any sort of physical examination. After several months, the individual was consuming 15 to 20 tablets of Percocet per day. He became addicted to Percocet and on or about May 1987, was admitted to a local hospital following a suicide attempt.

On July 10, 1987, the New Jersey Department of Law and Public Safety, Division of Consumer Affairs filed an administrative complaint charging Respondent with prescribing without medical justification, gross malpractice, and endangering the health or life of one or more persons in violation of the laws of the State of New Jersey. On July 16, 1987, Respondent was summarily suspended from the practice of medicine by the New Jersey State Board of Medical Examiners. This suspension continued until October 12, 1988, when Respondent was given limited authority to resume the practice of medicine. On April 1, 1988, Respondent surrendered his prior DEA Certificate of Registration.

On June 8, 1988, Respondent was indicted in the Superior Court of New Jersey, Monmouth County and charged with eight counts of unlawfully distributing a controlled dangerous substance and one count of knowingly maintaining premises resorted to by persons using controlled dangerous substances. On July 13, 1988, Respondent pled guilty to these charges and on August 12, 1988, was sentenced to three years probation, fined $8,400.00, and ordered to perform 200 hours of community service. In addition, Respondent's driver's license was revoked for one year.

In his written statement, Respondent argues that his convictions did not involve the sale or distribution of "hard drugs", such as cocaine, heroin or marijuana, and as a result, Respondent should not be classified with the common drug dealer and should be given the deference his position and profession requires. Respondent's contention is unworthy of serious consideration. The diversion of licit controlled substances into the illicit market is as much a problem in today's society as the distribution of illicit drugs. As a health care professional and DEA registrant, Respondent bears a heavy responsibility to ensure that the controlled substances he prescribes are not abused.

Respondent next argues that because the amount he charged "patients" was far below that charged by other practitioners in similar communities with equal medical expertise, one could not say that his motive for writing illegal prescriptions was money. Respondent's motivation is of no great consequence. The evidence in this case shows that Respondent knowingly and intentionally issued controlled substance prescriptions for no legitimate medical purpose. He falsified his medical records to justify such prescribing. His motivation for doing so is of little consequence.

Respondent contends that the amount of controlled substances he prescribed was far below what is normally prescribed by doctors in similar situations. The relevant issue here is not how much was prescribed, but whether the drug was prescribed for a legitimate medical need. As evidenced by the visits of the undercover Board investigators, Respondent issued controlled substance prescriptions outside the scope of professional practice and for no legitimate medical purpose.

Respondent attempts to explain his prescribing of Percocet to the individual that ultimately attempted suicide. Respondent states that the individual was a drug addict long before obtaining any drugs from Respondent and that this fact was well-known throughout the community. This explanation, however, further calls into question Respondent's ability to handle controlled substances responsibly. If, indeed, the individual was a known addict, then why did Respondent prescribe Percocet, a highly abused Schedule II narcotic.

The Administrator may deny an application for a DEA Certificate of Registration if he determines that the registration would be inconsistent with the public interest. Pursuant to 21 U.S.C. 823(f), "(i)n determining the public interest, the following factors will be considered:

(1) The recommendation of the appropriate State licensing board or disciplinary authority.

(2) The applicant's experience in dispensing, or conducting research with respect to controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health or safety."

It is well established that these factors are to be considered in the disjunctive, i.e., the Administrator may properly rely on any one or a combination of factors, and give each factor the weight he deems appropriate. See, *Henry J. Schwarz, Jr., M.D.*, Docket No. 88–42, 54 Fed. Reg. 16422 (1989); *Neveille H. Williams, D.D.S.*, Docket No. 87–47, 53 Fed. Reg. 23465 (1988); *David E. Trawick, D.D.S.*, Docket No. 86–69, 53 Fed. Reg. 5326 (1988).

In this case, the first through fourth factors apply. Respondent engaged in egregious misconduct which was an abuse of both his professional responsibilities as a physician and his responsibilities as a DEA registrant. This conduct led to his criminal convictions, and loss of his medical license for a period of time. Respondent's prescribing of controlled substances for no legitimate medical purpose illustrates his disregard for the tremendous responsibility which accompanies DEA registration. Respondent's registration is clearly contrary to the public interest.

The Administrator is not convinced that Respondent accepts the seriousness of his misdeeds and consequently, is not convinced that such misdeeds will not occur again in the future. Accordingly, the Administrator of the Drug

Enforcement Administration, pursuant to the authority vested in him by 21 U.S.C. 823 and 28 CFR 0.100(b), hereby ordered that the application for registration, executed on November 22, 1988, by Pompeyo, Q. Braga Bonado, M.D., be, and it hs hereby is, denied.

Dated: August 31, 1990.

Robert C. Bonner,

Administrator.

[FR Doc. 21307 Filed 9–11–90; 8:45 am]

BILLING CODE 4410-09-M

[Docket No. 89–3]

Lakshmi K. Kenue, M.D., Revocation of Registration

On December 16, 1988, the Deputy Assistant Admininstrator, Office of Diversion Control, Drug Enforcement Administration (DEA), issued an Order to Show Cause to Lakshmi K. Kenue, M.D. (Respondent), 30542 Southfield Road, Suite 230, Southfield, Michigan 48076. The Order to Show Cause proposed to revoke Respondent's DEA Certificate of Registration, BK0803379. The statutory basis cited in the Order to Show Cause was that Respondent's continued registration was inconsistent with the public interest as set forth in 21 U.S.C. 823(f) and 21 U.S.C. (a)(4). Specifically, the Order to Show Cause alleged that Respondent's registration was inconsistent with the public interest based on Respondent's participation in a conspiracy to unlawfully dispense controlled substances and defraud Medicaid by permitting unlicensed individuals to complete pre-signed prescriptions for controlled substances for individuals she never saw as patients.

By letter dated January 17, 1989, counsel for Respondent requested a hearing on the issues raised in the Order to Show Cause. The matter was placed on the docket of Administrative Law Judge Francis L. Young. Following prehearing procedures, a hearing was set to be held in Washington, DC on June 27 and 28, 1989. Upon request by both parties, however, the hearing was indefinitely continued. The parties entered into a Memorandum of Agreement in which they agreed that Respondent's DEA registration would remain suspended until the Michigan State Board of Medicine (Board) decided whether or not to reinstate Respondent's medical license. The Board had earlier temporarily suspended Respondent's license based upon her conviction of two counts of attempted Medicaid fraud. Respondent later applied for reinstatement of her license by the Board. By the terms of the Memorandum of Agreement, Respondent agreed to the revocation of her DEA Certificate of Registration, without a hearing, should the Board refuse to reinstrate her medical license.

On February 13, 1990, a state administrative law judge issued an opinion recommending that the Board find that Respondent failed to meet the requirements for reinstatement of her medical license. By final order dated April 6, 1990, the Board adopted the administrative law judge's opinion and denied reinstatement of Respondent's medical license. Upon motion by the Government and in accordance with the Memorandum of Agreement, the administrative law judge presiding over the DEA proceedings terminated the case before him by order dated May 18, 1990.

In view of the Memorandum of Agreement entered into by the parties, the Administrator has deemed Respondent to have waived her opportunity for a hearing, and hereby issues his final order pursuant to 21 CFR 1301.57 without a hearing and based upon the investigative file and the administrative record as it now appears. *See* 21 CFR 1301.54(c) and 1301.54(e).

The Administrator finds that based upon the actions of a competent state authority denying reinstatement of Respondent's medical license, Respondent is no longer authorized by state law to engage in the manufacturing, distribution, or dispensing of controlled substances. Without a state license, Respondent cannot maintain a DEA registration. 21 U.S.C. 824(a)(3). Further, in view of the Memorandum of Agreement entered into by the parties, the Administrator has deemed Respondent not only to have waived her opportunity for a hearing, but also to have consented to the revocation of her registration.

Accordingly, the Administrator of the Drug Enforcement Administration, pursuant to the authority vested in him under the provisions of 21 U.S.C. 824(a)(3) and 28 CFR 0.100(b), hereby orders that DEA Certificate of Registration, BK0803379, previously issued to Lakshmi K. Kenue, M.D., be and it is hereby, revoked. It is further ordered that any pending applications for renewal of that registration be, and they are hereby, denied.

This order is effective September 12, 1990.

Dated: August 31, 1990.

Robert C. Bonner,

Administrator.

[FR Doc. 90–21306 Filed 9–11–90; 8:45 am]

BILLING CODE 4410-09-M

Floyd A. Santner, M.D.; Denial of Applications

On March 30, 1988, the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration (DEA), issued an Order to Show Cause to FLoyd A. Santner, M.D., St. Francis Hospital, 25 West Hayden Street, Marceline, Missouri 64658. The Order to Show Cause proposed to deny his applications, executed on April 12, 1986 and January 19, 1987, for registration as a practitioner under 21 U.S.C. 823(f). The Order to Show Cause alleged that the registration of Dr. Santner would be inconsistent with the public interest, as that term is used in 21 U.S.C. 823(f) and 824(a)(4).

The Order to Show Cause was received by Dr. Santner on April 4, 1988. By letter dated May 3, 1988, Dr. Santner requested that DEA amend his applications for registration. However, Dr. Santner did not indicate whether he wanted to proceed with a hearing. By registered mail, Dr. Santner was sent a letter which again explained the procedures available to him pursuant to the Order to Show Cause. The registered mail receipt indicates that it was received on July 18, 1988. More than thirty days have passed since the letter was received by Dr. Santner and the Drug Enforcement Administration has received no response thereto. Therefore, the Administrator concludes that Dr. Santner has waived his opportunity for a hearing on the issues raised in the Order to Show Cause, and pursuant to 21 CFR 1301.54(d) and 1301.54(e), enters this final order based upon information contained in the investigative file 21 CFR 1301.57.

The Administrator finds that in 1977, the Pennsylvania State Police Department received numerous complaints from individuals who lived in the vicinity of Dr. Santner's office. The complainants stated that there was an inordinate number of people in their teens who left Dr. Santner's office stumbling and others who congregated on the street or on the lawns and sidewalks in the area. As a result of this information, state police officers conducted surveillance at Dr. Santner's office and saw many individuals, who in their opinion and experience, appeared to be under the influence of some type of substance.

The police surveillance further revealed that approximately ninety-five percent of the people that left Dr. Santner's office proceeded immediately to a nearby pharmacy. The officers interviewed the pharmacists at the pharmacy and examined the pharmacy

records for the period between February 1, 1978 and February 24, 1978. The records revealed that Dr. Santner had prescribed excessive quantities of Schedule II controlled substances, including 15,901 dosage units of Quaalude, 3,129 dosage units of Ritalin and 903 dosage units of Percodan.

Additionally, a subsequent prescription audit conducted by DEA revealed that during July and August 1979, the pharmacy filled over 1,900 of Dr. Santner's prescriptions for Quaalude, 300 mg. During the period from January 1, 1979 through October 24, 1979, this pharmacy purchased over 179,000 dosage units of Quaalude, 300 mg., most of which was used to fill Dr. Santner's prescriptions.

The extensive investigative file further reveals that on February 28, 1979, based on complaints, surveillance and a pharmacy survey, Upper Darby Police Officers executed a search warrant at Dr. Santner's office and seized patient records, financial ledgers and billing information. The documents seized during this search further substantiated the fact that Dr. Santner prescribed large quantities of controlled substances to patients on a continuous basis for no apparent medical condition. Seized appointment books showed that during the period between 1977 and 1978, Dr. Santner was seeing four to eight patients in each 15 minute block of time.

As a result of the investigation, Dr. Santner was arrested on February 28, 1979. A jury trial conducted in Delaware County, Pennsylvania, from September 7, 1979 to October 5, 1979, returned guilty verdicts on two counts of violating state controlled substance laws. On October 14, 1980, Dr. Santner was sentenced to six months in prison and a $5,000 fine for unlawful dispensing of controlled substances to a drug dependent person. Dr. Santner was also sentenced to two to four years imprisonment and a fine of $15,000 for unlawful dispensing of controlled substances by a practitioner.

Shortly after Dr. Santner's conviction, DEA investigators learned that he had moved his medical office to a room in a Holiday Inn in Philadelphia, Pennsylvania. He rented the room under a fictitious name and did not inform the management that he would be operating a medical office from the hotel room. The investigative file reveals that Dr. Santner continued to practice and write prescriptions in the same manner and quantity that he had done prior to his arrest. As a result, DEA served Dr. Santner with an Order to Show Cause and an Immediate Suspension Order on October 19, 1979. Following the completion of prehearing procedures, the administrative law judge established a date and place for a hearing. However, prior to commencement of the hearing, Dr. Santner and the Government filed a joint motion to stay the proceedings pending the outcome of post-trial motions and appellate proceedings arising out of the underlying criminal case.

On April 11, 1982, DEA received certification from the Pennsylvania Board of Medical Education and Licensure that Dr. Santner's license to practice medicine in Pennsylvania had been revoked. Due to this Board action, the Administrator revoked Dr. Santner's DEA registration. See *Floyd A. Santner, M.D.*, Docket No. 79–23, 47 Fed. Reg. 51831 (1982).

The Administrator finds that Dr. Santner's criminal conviction was overturned on July 9, 1982, due to a procedural error. Despite this reversal, the Administrator finds that the facts which underlie Dr. Santner's arrest demonstrate that he was a pernicious prescriber and cannot be trusted to handle controlled substances. The results of the prescription surveys revealed that Dr. Santner excessively and inappropriately prescribed controlled substances to a number of patients over extended periods of time. Additionally, testimony presented at the criminal trial revealed that Dr. Santner knew, or should have known, that a significant number of his patients to whom he issued prescriptions for controlled substances, were drug dependent. Dr. Santner's receptionist testified that she noticed that a lot of the patients that came into the office were very glassy-eyed, tired-looking, falling all over the place, bumping into things, and spoke with slurred voices. A pharmacist testified that he turned some of Dr. Santner's patients away and refused to fill their prescriptions when they "stumbled around a little bit and just acted a little bit unusual." Additionally, a patient for whom Dr. Santner prescribed controlled substances, including Quaalude and Valium, told Dr. Santner she was on a methadone program.

The Administrator further finds that medical experts reviewed Dr. Santner's patient records. One expert concluded that the quantities and frequencies of the controlled substances prescribed presented a grave threat to the health, well-being, and life of the individuals, while no cogent pharmacologic basis had been presented to justify their use for the patient complaints. Another expert concluded that Dr. Santner excessively prescribed controlled substances and that great mental and physical deterioration to the patients would result if they took the quantities prescribed. A third expert concluded that the quantity of Quaalude, Valium, Doriden and Talwin, prescribed by Dr. Santner were more than sufficient to produce both psychological and physical dependence in humans. This expert further concluded that in many cases, there was not sufficient time to allow for metabolism of the drugs by the patient from one visit to the next and if the patient actually consumed all of the medication prescribed between visits an overdose would have resulted. Another expert noted that Dr. Santner's patient records contained meager information and that there was an absence of variation on diagnoses and individualized treatment. In several cases, the treatment was obviously not in the patient's best interest, as demonstrated by inadequate follow-up, a lack of alteration in medication and an absence of adequate explanations for the treatment given.

A DEA registration authorizes a physician to prescribe or dispense controlled substances only within the usual course of his or her professional practice. For a prescription to have been issued within the course of a practitioner's professional practice, it must have been written for a legitimate medical purpose within the context of a valid physician-patient relationship. Legally, there is absolutely no difference between the sale of a illicit drug on the street and the illicit dispensing of a licit drug by means of a physician's prescription. In the instant case, Dr. Santner's prescribing practices were deplorable and clearly outside the scope of legitimate medical practice. Dr. Santner has shown a total disregard for the health and welfare of his patients, demonstrated a lack of appreciation for the inherently dangerous nature of the drugs he prescribed and has abandoned the responsibilities placed upon him by possession of a DEA registration. Dr. Santner's past conduct constitutes a flagrant abuse of authority and leads the Administrator to conclude that Dr. Santner's registration would be inconsistent with the public interest. 21 U.S.C. 823(f).

Additionally, the Administrator finds a second statutory basis for denial of Dr. Santner's applications. Dr. Santner materially falsified two applications for registration under the Controlled Substances Act, a statutorily sufficient basis for denial of a DEA registration. 21 U.S.C. 824(a)(1).

The Administrator finds that Dr. Santner falsified his application executed on April 12, 1986, by indicating that he was authorized to handle

controlled substances in the Commonwealth of Pennsylvania. Dr. Santner's Pennsylvania license was revoked in 1982, and although that license was reinstated on March 12, 1986, the reinstatement was subject to the condition that Dr. Santner not practice medicine and surgery within the borders of the Commonwealth of Pennsylvania. Dr. Santner also falsified his application executed on January 19, 1987, by indicating that he was authorized to handle Schedule II–V controlled substances in the State of Missouri. However, pursuant to his Missouri Controlled Substances Registration, Dr. Santner may prescribe only the following controlled substances: Tylenol No. 3, Tussi-organidin and Valium. A further condition placed on the Missouri registration was that Dr. Santner could not lawfully write prescriptions for controlled substances until he was issued and had received a DEA registration. The investigative file reveals that in violation of this condition, Dr. Santner had, on six occasions, written prescriptions for controlled substances and received them from the floor stock at the hospital where Dr. Santner is employed. Dr. Santner then dispensed them to in-house patients. These prescriptions written during the period of September 13, 1987 to March 19, 1988, were for Tylenol No. 3, Lomotil and Percodan. All prescriptions were written without proper authorization.

Dr. Santner has a long history of controlled substance violations. No evidence of explanation or mitigating circumstances has been offered on behalf of Dr. Santner. The Administrator cannot conceive of any explanation which would excuse Dr. Santner's criminal and unprofessional conduct. To protect the public interest and to prevent further diversion of controlled substances, the Administrator concludes that Dr. Santner's registration would be wholly inconsistent with the public interest. 21 U.S.C. 823(f). In addition, the Administrator finds that Dr. Santner materially falsified his applications for registration. 21 U.S.C. 824(a)(1).

Accordingly, the Administrator of the Drug Enforcement Administration, pursuant to the authority vested in him by 21 U.S.C. 823 and 824 and 28 CFR 0.100(b), orders that the applications for registration, executed by Dr. Santner on April 12, 1986 and January 19, 1987, be, and hereby are, denied. It is further ordered that any pending applications for registration submitted by Dr. Santner are also denied.

This order is effective September 12, 1990.

Dated: August 31, 1990.

Robert C. Bonner,

Administrator.

[FR Doc. 90–21038 Filed 9–11–90; 8:45 am]

BILLING CODE 4410–09–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–24,606]

George Harris Oil Co.; Abilene, TX; Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on July 16, 1990 in response to a worker petition received on July 16, 1990 which was filed on behalf of workers at George Harris Oil Company, Abilene, Texas.

Petitioners were unable to provide any information regarding company officials who could be contacted for appropriate company data. Without company data, the Department cannot make a determination. Consequently, the investigation has been terminated.

Signed at Washington, DC, 30th day of August 1990.

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

[FR Doc. 90–21373 Filed 9–11–90; 8:45 am]

BILLING CODE 4510–30–M

[TA–W–24,348]

Pacific Brands Footwear Fenton, MO; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on May 25, 1990 applicable to all workers of Pacific Brands Footwear, Fenton, Missouri. The notice was published in the **Federal Register** on June 7, 1990 (55 FR 23310).

Based on new information from the company, a few additional workers are currently being retained beyond the May 24, 1990 termination date for close down operations. Therefore, the certification is amended by deleting the termination date. The amended notice applicable to TA–W–24,348 is hereby issued as follows:

All workers of Pacific Brands Footwear, Fenton, Missouri who became totally or partially separated from employment on or after April 18, 1989 are eligible to apply for adjustment assistance under section 223 of the Trade Act of 1974.

Signed at Washington, DC this 31st day of August 1990.

Marvin M. Fooks,

Director, Office of Trade Adjustment Assistance.

[FR Doc. 90–21372 Filed 9–11–90; 8:45 am]

BILLING CODE 4510–30–M

Mine Safety and Health Administration

[Docket No. M–90–10–M]

Sunshine Mining Company; Petition for Modification of Application of Mandatory Safety Standard

Sunshine Mining Company, P.O. Box 1080, Kellogg, Idaho 83837 has filed a petition to modify the application of 30 CFR 57.11051(b) (escape routes) to its Sunshine Mine (I.D. No. 10–00089) located in Shoshone County, Idaho. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that escape routes be marked with conspicuous and easily read direction signs that clearly indicate the ways of escape.

2. The posting of emergency exit signs would encourage employees to make a decision on which way to go without the benefit of any information on the location of a fire. These employees would have the potential of exiting into the contaminated split of the ventilation system, thus resulting in a diminution of safety.

3. The escape plan calls for employees, upon smelling smoke or stench, to immediately go to the shaft station through which they entered the mine, where an assigned person will direct them to exit the mine through the appropriate route.

4. The active part of the mine is divided into two separate ventilation circuits. There are two major interior mine shafts, effectively isolated from each other, that carry intake ventilation air to the two distinct and separated active areas of the mine. Fresh air flows from the two shafts to all work areas in the separate systems.

5. For these reasons, petitioner requests a modification of the standard.

Request for Comments

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health