STATE OF NORTH CAROLINA  
NORTH CAROLINA BOARD OF PHARMACY

IN THE MATTER OF  
SHARON W. LAWRENCE  
License Number 11523  
ORDER AND FINAL DECISION

THIS MATTER came before the Board on April 15, 2008 upon two requests for action by the Board. First, Respondent Sharon Lawrence requested reinstatement of her license, which the Board summarily suspended by a May 8, 2007 Order. Second, Board staff requested that the Board impose a final order of discipline upon Respondent pursuant to North Carolina General Statutes §§ 90-85.38(a)(6), (7) and (9).

Based upon the testimony of witnesses Jack W. Campbell, IV, Courtney Gray, Respondent Lawrence, Brian Irving, the deposition testimony of Catrina Foust, the exhibits tendered by Board Staff as Exhibits 1-8 and admitted by the Board, and the exhibits tendered by Respondent Lawrence and admitted by the Board, the Board hereby enters the following findings of fact and conclusions of law:

**FINDINGS OF FACT**

1. From September 17, 1991 through May 8, 2007, Respondent Sharon Lawrence held license number 11523 from the Board.

2. On January 16, 2007, the Board held a hearing on various disciplinary charges against Respondent Lawrence. Following the hearing, the Board entered a Final Decision on the charges (the "Final Decision").

3. In the Final Decision, the Board found that Respondent Lawrence had made a number of dispensing errors and committed related violations.
4. The Final Decision imposed an indefinite suspension of Respondent Lawrence’s license to practice pharmacy, but it stayed that indefinite suspension for a period of three (3) years, based upon Respondent Lawrence’s compliance with a number of conditions. Those conditions included the following:

a. “Respondent shall violate no laws governing the practice of pharmacy or the distribution of drugs.” (Condition 1(f.))

b. “Respondent shall violate no rules and regulations of the Board.” (Condition 1(g.))

c. “Respondent shall promptly provide documentation of any reported errors to the Board’s Executive Director within five (5) business days of such error.” (Condition 1(h.))

5. The Final Decision explicitly provided: “If Respondent fails to comply with any terms or conditions of this Order, the three-year stay described above shall be lifted and Respondent may be subject to additional disciplinary action by the Board.”

6. When the Final Decision was rendered in January 2007 and at all times thereafter until May 8, 2007, Respondent Lawrence was employed as a pharmacist at Kerr Drug, Permit Number 6971, 1821 Hillandale Road, Durham, North Carolina.


8. On or about February 5, 2007, Respondent Lawrence erroneously dispensed prescription #2838784 as Methadone 10mg instead of the prescribed drug, Methadone 5mg. Respondent Lawrence therefore dispensed a Schedule II controlled substance that had not been
prescribed in the strength dispensed, doubling the prescribed strength and creating a substantial risk of overdose to the patient.

9. On or about April 7, 2007, Respondent Lawrence erroneously refilled prescription #6833147 as Metformin 500 mg instead of the prescribed drug, Metformin Extended Release 500mg.

10. On or about April 20, 2007, Respondent Lawrence erroneously refilled prescription #6829240 as Cymbalta 30mg instead of the prescribed drug, Enalapril 10mg.

11. On or about April 20, 2007, Respondent Lawrence erroneously refilled prescription #6837578 as Metoprolol Extended Release 25mg instead of the prescribed drug, Metoprolol 25mg.

12. On or about April 20, 2007, Respondent Lawrence erroneously dispensed prescription #6845847 as Spiriva instead of the prescribed drug, Serevent.


14. On or about May 4, 2007, Respondent Lawrence erroneously dispensed prescription #6847182 as Coumadin 1mg instead of the prescribed medication, Coumadin 5mg.

15. Each one of these errors constituted negligence in the practice of pharmacy.

16. Respondent Lawrence did not report any of the foregoing errors to the Executive Director of the Board, as required by the Final Decision.

17. The Final Decision does not limit Respondent Lawrence’s obligation to report only those errors of which she was aware at the time. Nevertheless, Respondent Lawrence was aware of at least three of the errors, those occurring on or about April 20, 2007.
18. After Respondent Lawrence erroneously dispensed prescription #6845847 as Spiriva instead of the prescribed drug, Serevent, the patient called the pharmacy to complain. Catrina Foust, a cashier at the time, initially fielded the call, but then passed the telephone to Respondent Lawrence, with whom the conversation continued.

19. As to the other April 20, 2007 errors, after Respondent Lawrence erroneously refilled prescription #6829240 as Cymbalta 30mg instead of the prescribed drug, Enalapril 10mg, and erroneously refilled prescription #6837578 as Metoprolol Extended Release 25mg instead of the prescribed drug, Metoprolol 25mg, Respondent Lawrence herself reported the errors to R.Ph. Courtney Gray, the pharmacy manager.

20. Respondent testified that she was aware that she was required to report these known errors to the Board but that she decided not to do so because she knew that reporting the errors to the Board could lead to additional discipline.

21. As an aggravating factor, the Board has considered Respondent’s history with the Board, including the fact that she made a large number of errors within weeks after having been disciplined for similar errors.

**CONCLUSIONS OF LAW**

1. The evidence demonstrates that Respondent violated one or more of the following statutes, rules and decisional authority:
   
   a. North Carolina General Statutes § 90-85.38(a)(6);
   
   c. North Carolina General Statutes § 90-85.38(a)(7);
   
   d. North Carolina General Statutes § 90-85.38(a)(9);
   
   e. North Carolina General Statutes § 90-106;
   
   f. North Carolina General Statutes § 90-108;
g. 21 N.C.A.C. 46.1805;
h. 21 U.S.C. § 331;
j. 21 U.S.C. § 352; and

2. In the Final Decision, the Board provided that a failure to comply with the conditions of the Final Decision would result in the lifting of the stay of the indefinite suspension of Respondent Lawrence’s license. That stay should be lifted.

3. In addition, separate and apart from the violations of the Board’s Order of January 16, 2007, the Board finds that the nature of Respondent’s negligence and violation of the Pharmacy Practice Act and regulations between February 5, 2007 and May 4, 2007, justifies imposing a permanent suspension of her license.

WHEREFORE, the Board hereby orders that Ms. Lawrence’s request to lift the summary suspension of her license to practice pharmacy is DENIED. Furthermore, the Board Staff’s request for discipline to be imposed pursuant to North Carolina General Statutes § 90-85.38(a)(6), (7) and (9) is hereby GRANTED, and Respondent’s license to practice pharmacy, license number 11523 is hereby PERMANENTLY SUSPENDED.

This the 15th day of April, 2008.

NORTH CAROLINA BOARD OF PHARMACY

By: 

[Signature]

Jack W. Campbell, IV
Executive Director
CERTIFICATE OF SERVICE

I certify that on April 25, 2008 I caused a copy of this Order and Final Decision to be served on Petitioner by registered mail, return-receipt requested.

Jack W. Campbell IV
Executive Director