

- I. Give the generic name, therapeutic uses and essential advices for patients for each of the following products : (每題四分)
- A、Ciproxin
 - B、Fosamax
 - C、Lipitor
 - D、Relifex
 - E、Talsutin
 - F、Xalatan
 - G、Zolofl
 - H、Zyprexa
- II. For the following pair of drugs, describe the mechanism of interactions and the clinical effect that may occur due to their concomitant use: (每題四分)
- A、Warfarin — Cimetidine
 - B、Digoxin — Quinidine
 - C、Levodopa — Moclobemide
 - D、Cisapride — Clarithromycin
 - E、Phenytoin — Valproate
- III. How to instruct a patient on the proper administration and use of the following pharmaceutical products? (每題四分)
- A、Ophthalmic solution
 - B、Metered dose inhaler
 - C、Rectal suppository
- IV. Explain "Geometric dilution". When should a pharmacist need to use such a technique? (十分)
- V. What are the contents of the labels for outpatient prescriptions, which are requested by the Department of Health? (十分)
- VI. 閱讀下列二段文章後，請評論臺灣目前醫療用藥的作業體系與用藥安全的關係。(十六分)
- 「Outside health care, experts have found that the most common cause of defects is the production process itself, not the individuals within it. Berwick, Laffel and Blumenthal, and Leape have taken the position that this idea applies in health care

(背面仍有題目,請繼續作答)

as well. According to the philosophy of total quality management, the true cause of an accident is not viewed simply as a "human error", but as the result of a system that allowed an operator error to result in an accident.

Leape has recently written about error in medicine, and has made the point that errors are an everyday occurrence, and that everyone makes many daily.

Fortunately, most errors have few irrevocable consequences, but errors in medication use can be harmful. Though traditional medical systems have focused on finding bad practitioners, or "bad apples," particularly when medications are involved, most errors are made by competent practitioners. In evaluating 264 serious medication errors, Leape et al identified no instances in which there was a pattern of repeated error by an individual. These data suggest that effective prevention strategies should focus primarily on the systems for giving drugs, and only secondarily on the individuals involved in the process.」

「The availability of thousands of drug products is only one variable that provides ample opportunity for errors in the selection, distribution, and administration of medications. Other interacting components that may be present within a single institution include hundreds (thousands in large facilities) of different patients and conditions, hundreds of staff members, different types of practitioners, staff turnover, old and new equipment and technology, and ineffective processes for getting the right drug to the right patient at the right time. In addition, the opportunities for serious ADEs are more common today, given the higher potency of medicines, the increasing number of medications available, the uniqueness, of drug delivery systems, and the increasing number of medicines used per patient」