I. Give the generic name, therapeutic uses, and essential patient advice for each of the following products: （四十分）

1. Reductil
2. Lescol
3. Roaccutane
4. Aprovel
5. Wellbutrin SR
6. Efexor
7. Mycobutin
8. Hytrin
9. Intal eye drop
10. Pletaal

II. The following pairs of drugs should not be administered concomitantly. Explain the reasons as well as give the generic names and therapeutic uses. （三十分）

1. Isodil – Cialis
2. Diflucan – Prepulsid
3. Zanidip – Grapefruit juice
4. Adenocor – Persantin
5. Cravit – Ulsanic

III. 下列兩篇文章中，第一篇取自 Chapter 2. Social and behavioural aspects of pharmacy. In Pharmaceutical Practice 3rd ed. Edited by A. J. Winfield and R. M. E. Richards，第二篇則爲民生報醫藥新聞中的專文。請於閱讀後回答下列議題：（三十分）

1. 引發自我照護趨勢的原因有那些？
2. 自我照護有那些利弊？
3. 藥師在民眾的自我照護上可以做什麼？
4. 藥師須具備那些專業能力才足以協助民眾自我照護？
5. 健保應否給付指示藥品？
6. 就自我照護而言，比較我國與歐美國家在民眾的態度與醫療環境有什麼差異？

一、 During the 1970s and 1980s a new trend emphasizing the role of the individual and patient emerged as a part of a more general trend called consumerism. People have become more committed to getting and taking control of their own lives and assessing the impact of their behavior on their health. Different self-care and self-help movements were a direct result of this

（背面仍有題目，請繼續作答）

trend. The same trend has been obvious in most countries although the starting time and speed of it has varied. At the same time the dominant role of the health care personnel has diminished. With new information sources, and especially the Internet, the trend continues to grow and spread to countries where physicians and other health care personnel still dominate. This new trend has included a much more critical attitude towards what is being done in health care and the quality of care given. Patients are asking more questions, seeking more information and taking a more active role in their health care. They have a better basic education and knowledge especially about their own disease and treatment of that disease.

The new trend has also put increasing demands on pharmacists regarding their knowledge base especially in therapeutics but also in communication. The priorities in treatment goals may differ between the patient and the treating physician and this calls for negotiation. One aspect is that patients' views have to be taken seriously.

According to the self-care philosophy people should be given more responsibility for their own health. One way this can be achieved is to emphasize the role of self-care in treating minor ailments using home remedies and an increased number of self-medication products. Especially in the1980s and early 1990s this trend was obvious in many countries. The most common 'action' in response to a perceived health problem has been to ignore the problem or wait for a few days. It is estimated that some 30-40% of healthy problem are dealt with in this way. Of those who take some action 75-80% self-diagnose and use self-treatment, while only 20-25% seek professional care. Therefore a seemingly small change in this ratio (towards using more professional care) has a substantial impact and burden on the official health care system. Of those who use self-treatment some 70-90% are self-medicating and of those self-medicating some 80% are using OTC drugs. Home remedies like onion, garlic, warm drinks, in addition to different herbal products, vitamins and minerals, are widely use over the world. Some of the newly emerging preparations are marketed with high promises of eternal youth and health, the evidence base being nonexistent or weak.

Before people decide to seek medical care for their symptoms they get and seek advice from friends, relatives and coworkers. These advisors form a lay-referral network that provides its own information and interpretation regarding the symptoms, recommending home remedies, self-medication, professional help or consulting another 'lay expert' who may have had a similar problem.

The pharmacy is often the first place where people come to seek help within the health care system. Increased self-care includes also potential risks in that lay people may not be able to distinguish between serious and non-serious symptoms. Certain situations may demand professional care without further delay caused by inappropriate self-medication practices. The lay-referral network can in some cases be guilty of causing the delay in seeking care. This treatment delay has been divided into three stages, i.e. appraisal delay, illness delay and utilization delay. Appraisal delay is the time it takes to interpret a symptom as a part of an illness. Illness delay is the time between recognizing the illness and the decision to seek care. Finally utilization delay is the time between the decision and actually using a health service.

There has also been concern about misuse of OTC drugs, like laxatives, codeine-containing cough medicines, etc. The other side of the coin is saved resource in health care when there is less reliance on professionals. This seems to be an important aspect as health care budgets tend to increase more rapidly than the general inflation rate.

二、【2005-04-01/民生報/A15 版/醫藥新聞】衛生論點

指示藥不給付的弔詭與矛盾 -- 張耀懋

感冒藥、胃藥等指示用藥健保不給付的政策，在立法院介入後，愈趨盤根錯節。這項牽動藥廠利益分配的措施，在各利益團體不斷角力下，爭議愈趨白熱化，問題卻漸失焦。依健保法規定，不給付指示用藥似是在所難免，只是這項政策形成背後充滿了許多弔詭與矛盾，台灣就醫環境是否已趨成熟，更是衛生單位不容迴避的議題。

首先是到底是指示用藥不給付？還是感冒等小病要「自我療護」，不要看醫師。兩者也許有層次上的牽連，卻是兩套不同做法。只不過，從健保局透露不給付指示用藥的訊息後，健保局也好、衛生署也罷，幾乎是全力宣導「感冒不要上醫院！」等自我療護的觀念。

若依健保法指示用藥不給付的規定，民眾一樣可拿健保卡就醫看病，醫師一樣開給處方箋，其中指示用藥的部分，需由病患自行買單。醫師還是爲民眾的大小病把第一關，因此，在這階段我們較關心的是，被推入自費市場以後的指示用藥的藥價是否因此一飛沖天；而少了健保審核機制，醫師開藥會不會偏差。

在此一議題上，衛生單位不斷指摘國人胃藥等「味素藥」用得過於浮濫。但是，用藥浮濫的弊病，似應由健保局加強審核及醫師自我提高素質導正，而不是是浮不浮濫均不給付。因爲用藥浮濫根本就是審核的問題與指示用藥給不給付絕對沒

(背面仍有題目,請繼續作答)

有必然關係，這個弔詭也反射最近醫界對此問題的態度上。據相關官員的轉述，醫界代表在相關會議上幾都支持不給付的政策。頗堪玩味的是，若沒有總額預算的上限限制，醫界的態度是否仍會持相同態度。

再者，歐美等先進國家的健保組織真的都如衛生單位所宣稱的不給付指示用藥與成藥嗎？其實如加拿大是幾乎所有的藥品都不給付，有的國家是成藥不給付，有的國家只給付救命藥；也有更多的國家或健保組織是尊重醫師專業判斷，只要醫師開出來的處方箋，基本上是給付的，只是部分負擔額度不同。這些均可能是當財務考量凌駕於專業判斷的隱憂。

健保法不給付的是前者，衛生單位卻一步跳到自我療護，也就是希望輕症病患不要看病，靠自我抵抗力或自行到藥局買成藥治療。根本未正視不給付後，對民眾帶來的衝擊。

退一步言，即使衛生單位現在要推動的是自我療護的觀念，但是，我們不禁要問的是，台灣的醫療體系與民眾的衛生觀念已經堅強到可以成爲自療護的堅強後盾了嗎？「自我療護」在衛生官員的口中似乎就與「小病不必看病」、「自己到藥房買買成藥即可」畫上等號，而且「歐美等先進國家都是這麼做的！」。但是，歐美各國之所以可以減少用藥量的原因之一，是因爲有堅實的家庭醫師制度，很多家庭醫師可 24 小時回答病患的問題，在診間的說明非常詳盡。醫師看完診後，開完處方後，會詳細地交代病患，病程可能會如何進行，服了藥以後，會有那些症狀出來，什麼症狀民眾可以不必擔心，出現什麼症狀應立即打電話與診所連絡，什麼狀況又應該立即回診，又在什麼狀況下，該直奔特約醫院急診，巨細靡遺。這樣的體系，可以培養民眾更好的衛生與自我療護能力，而且有堅實的家庭醫師 24 小時當民眾的醫療顧問後盾，而不是一聲令下不給付，就將輕病民眾一腳踢離健保照護傘外，任令民眾自我療護─自己當起家庭醫師。也許醫界有心，但是，醫界可能又要抱怨，一個病患二百多元的診療費，如何建構如此完善的家醫體系。

若醫師訓練、民眾教育未臻完備，驟然不給付指示用藥，是否會在民眾的誘發與市場競爭下，反讓原本應開給藥性溫和的指示用藥者，反以藥價更高、藥性更強的處方用藥取代。健保省下區區的 23 億元，卻讓整體的社會支出倍數成長。另外，中低收入等弱勢族群拖成重症比率會不會因而拉升，這攸關人命的影響，恐怕也是在財務考量外，不得不正視的另一命題。

就健保法的條文而言，健保局似乎沒有理由與立場違抗，況且現在健保給付的指示用藥，多是公、勞保時代核准的用藥，也形成舊藥全部給付、新藥全被排除在給付名單的不公平現象，對病患也並非大利益考量。指示用藥不給付確實有其立論點，也可以導正台灣「過度醫療」的文化，只是，衛生署擬好全盤的作戰策略了嗎？