Analýza systémových nedostatkov v postgraduálnom vzdelávaní zdravotníckých záchranárov v Slovenskej republike

Analysis of systemic deficits in the Postgraduate education of Paramedics in the Slovak Republic

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Abstract

Education of paramedics (EMT) in Slovakia occurs within a rapidly evolving clinical environment, yet the legislative framework and institutional conditions only partially address the need for adaptive, evidence-based training. Objective: To identify and prioritise systemic barriers to postgraduate education of paramedics in the Slovak Republic and to formulate recommendations for a standardised model of continuing professional development (CPD). Methods: A mixed-methods design was adopted: (1) systematic analysis of relevant legislation and scholarly literature; (2) an online questionnaire survey (1 August 2023 - 1March 2024) involving 1 679 respondents from the four Visegrád countries (Slovakia = 408); and (3) semi-structured interviews with eight experts. Triangulated data were synthesised, and deficit priorities were visualised in a heat map using urgency and impact on quality as criteria. Results: Five key thematic deficits (T1-T5) emerged. The most critical was the absence of a state-guaranteed adaptation programme (T1), followed by non-uniform in-house training (T2), limited postgraduate support (T3), lack of standardised clinical guidelines (T4) and a largely formal system of continuing education (T5). Almost 48 % of respondents rated their preparation as average and 32 % as inadequate. Conclusions: Educational fragmentation threatens the homogeneity of clinical competence within emergency medical service crews. The study proposes a national, legislatively anchored model for adaptation and continuing education based on standardised curricula, simulation-based training and external quality audits.

Keywords: paramedic, education, Integrated Rescue System, pre-hospital health care, legislation

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Abstrakt

Vzdelávanie zdravotníckych záchranárov (ZZ) na Slovensku sa uskutočňuje v prostredí rýchlo sa meniacej klinickej praxe, no legislatívny rámec a inštitucionálne podmienky iba čiastočne odrážajú potrebu adaptívneho, dôkazmi podloženého vzdelávania. Cieľ: Identifikovať a hierarchizovať systémové bariéry postgraduálneho vzdelávania ZZ v Slovenskej republike a navrhnúť odporúčania pre štandardizovaný model kontinuálneho profesijného rozvoja. Metodika: Zvolený bol zmiešaný dizajn: (1) systematická analýza právnych noriem a odbornej literatúry, (2) online dotazníkový prieskum (1. 8. 2023 – 1. 3. 2024) medzi 1 679 respondentmi zo štyroch krajín V4 (SR = 408), (3) polostruktúrované rozhovory s ôsmimi expertmi. Dáta boli triangulované; priority nedostatkov sa vizualizovali pomocou heatmapy (kritériá: naliehavosť × dopad na kvalitu). Výsledky: Analýza odhalila päť kľúčových tematických deficitov (T1-T5). Najkritickejší je absentujúci štátom garantovaný adaptačný proces (T1), nasledovaný nejednotným interným vzdelávaním (T2), limitovanou postgraduálnou podporou (T3), chýbajúcou štandardizáciou klinických postupov (T4) a formálnym systémom kontinuálneho vzdelávania (T5). Takmer 48 % respondentov hodnotí svoju prípravu ako priemernú a 32 % ako nedostatočnú. Záver: Fragmentácia vzdelávania ohrozuje homogenitu klinickej spôsobilosti posádok ZZS. Štúdia navrhuje národný, legislatívne ukotvený model adaptácie a kontinuálneho vzdelávania založený na štandardizovaných učebných osnovách, simuláciách a externom audite kvality.

Kľúčové slová: zdravotnícky záchranár, vzdelávanie, Integrovaný záchranný systém, prednemocničná zdravotná starostlivosť, legislatíva

Introduction

Rapid advances in medical science and technology are placing ever-greater demands on prehospital emergency care. Paramedics form the first link in the chain of survival, and the quality of their field decisions and interventions directly determines patient prognosis. Although the current Slovak legal framework—defined chiefly by Acts No. 579/2004 Coll. and No. 578/2004 Coll.—sets out the basic conditions for professional practice, it only partially acknowledges the need for systematic, adaptive and lifelong learning in an environment characterised by high uncertainty and time pressure, a shortcoming highlighted by Holzer (2020) and Mikuš (2019). International guidelines repeatedly emphasise that simulation-based continuing education underpinned by standardised clinical protocols can reduce mortality in emergency situations by as much as fifteen per cent (WHO, 2021). Yet the practice of Slovak emergency medical service (EMS) providers remains fragmented: a national adaptation programme is lacking, in-service training methods are inconsistent, and differences in crew preparedness can undermine both intervention quality and patient safety (Kučera et al., 2022).

The present article addresses this knowledge gap through a comprehensive analysis that integrates a legislative review, empirical data and the perspective of professional practice. In the first phase we systematically examined the relevant statutes, decrees of the Slovak Ministry of Health and the specialist literature on paramedic education, crisis management and pre-hospital care. The second phase comprised a large-scale questionnaire survey carried out from 1 August 2023 to 1 March 2024 among paramedics in the four Visegrád countries; 1 679 valid responses were obtained (Slovakia 408, Czechia 414, Poland 440, Hungary 417). The third data source consisted of semi-structured interviews and electronic consultations with educators, EMS managers and clinical instructors, which enabled the quantitative findings to be interpreted within a broader operational and cultural context.

The aim of the study is to identify and rank the systemic barriers to effective postgraduate education of paramedics in the Slovak Republic and to propose an evidence-based framework for a standardised model of continuing education. The results presented below offer not only an analytical snapshot of the current situation but also concrete starting points for legislative and institutional interventions designed to enhance the quality, safety and efficiency of prehospital emergency care nationwide.

Methodological Framework and Sources

To investigate paramedic education we adopted a mixed-methods design that combines qualitative and quantitative approaches. The initial phase focused on a detailed legal analysis: Act No. 579/2004 Coll. on Emergency Medical Service, Act No. 578/2004 Coll. on Healthcare Professionals and the current decrees of the Ministry of Health governing educational requirements in the health professions. This was followed by a systematic review of scientific databases and specialised monographs on pre-hospital emergency care, crisis management and healthcare pedagogy, drawing primarily on the work of Holzer (2020),

Mikuš (2019), WHO methodological recommendations (2021) and the empirical findings of Kučera et al. (2022).

To obtain current data we conducted an extensive online survey in the Visegrád Group countries between 1 August 2023 and 1 March 2024. Questionnaires were distributed to more than one thousand EMS stations, yielding 1 679 responses—408 from Slovakia, 414 from Czechia, 440 from Poland and 417 from Hungary. The large sample enabled cross-national comparison and enhanced statistical reliability.

To place the quantitative results in the context of everyday practice, we carried out a series of semi-structured interviews and electronic consultations with key actors—experienced paramedics, secondary- and tertiary-level educators and physicians involved in crew training. By triangulating these three data streams—legislative review, questionnaire survey and expert interviews—we were able to pinpoint more precisely the systemic barriers that slow the introduction of a unified and effective model of paramedic education in Slovakia.

Selected Empirical Findings

The legal analysis confirmed that although statutes and decrees specify minimum training requirements, no mechanism ensures regular curriculum updates, a clearly defined adaptation programme for newly recruited paramedics or a coherent system of continuing professional development. Experts and survey respondents agreed that the most significant gaps arise in transferring modern medical and technological advances into day-to-day training activities within EMS providers.

The survey showed that almost half of paramedics rate their professional preparation as merely average; nearly one-third are dissatisfied, and only one in fifteen considers it excellent. Nevertheless, most participants regard education and training as critically important, indicating that motivation for professional growth exists but is hampered by a limited supply of high-quality programmes tailored to current practice needs. From a practical standpoint, our findings confirm that paramedics are willing to expand their competencies when accessible, well-designed learning opportunities—based on modern training techniques, realistic simulations and standardised clinical protocols—are available. These insights provide a foundation for further discussion of legislative and institutional interventions that could improve postgraduate education and frontline performance in pre-hospital emergency care.

Identified Deficiencies in the Paramedic Education System

Analysis of the detected deficits and the resultant data delineated several key thematic areas whose systematic resolution is a prerequisite for reforming postgraduate paramedic education in the Slovak Republic. The priorities summarised in Table 1 build on the latest scholarly evidence while simultaneously reflecting concrete weaknesses in practice, as revealed through expert interviews, document analysis and feedback from emergency medical service providers themselves.

Code	Area	Identified deficiency	Implications for practice
T-1	Legislation	Absence of a legally defined	different levels of
	_	adaptation process for newly	preparedness, risk of errors in
		hired paramedics	the initial period of service
T-2 Internal Non-existence of manda		Non-existence of mandatory	significant variability in
	Education	internal training characteristics	content standards between
		for EMS providers	providers
T-3	Postgraduate	Weak support for externally	limited exposure to modern
	Support	oriented educational activities	trends, lower development of
			practical skills
T-4 C Pro	Clinical	Lack of standardization of pre-	heterogeneous quality of
	Procedures	hospital care performance	interventions and limited
			possibility of measuring
			performance
T-5	Continuing	Unclear legislative	stagnation of professional
	Education	requirements for mandatory	level
		lifelong learning	

Table 1 - The identified deficiencies derive from the theoretical framework (source: authors' own elaboration).

Thematic Deficits (T 1–T 5)

The legislative domain, specifically the adaptation process (T 1), is the most critical systemic deficit. In the absence of a nationally defined induction framework, recent graduates enter practice with highly variable levels of preparedness. Because adaptation schemes are left to individual emergency-medical-service (EMS) providers, the scope of mentoring and performance appraisal differs markedly, and patients ultimately experience this inconsistency in the variability of crews' first responses-arguably the most sensitive link in the chain of survival. Internal training (T 2) is likewise unregulated; no minimum content or frequency is prescribed, so providers range from structured annual curricula to ad-hoc lectures, producing wide disparities in clinical skill. Post-graduate support (T 3)-international placements, highfidelity simulation courses and workshops-should drive innovation, yet meagre institutional and financial backing limits paramedics' exposure to current trends and slows the transfer of modern techniques into the field. Without nationally binding standards for pre-hospital interventions (T 4), crews operate in a broad interpretative zone shaped by local custom, a heterogeneity that complicates data collection, quality audit and the development of evidencebased practice. Finally, continuing education (T 5) is statutorily required, but legislation sets no clear parameters for the quality or relevance of activities; a credit system that rewards quantity rather than demonstrable competence encourages purely formal compliance and yields little genuine professional growth.

Practical shortcomings

Qualitative interviews with field experts together with e-mail correspondence and document analysis, revealed eleven principal shortcomings in postgraduate education among Slovak EMS providers (Table 2). Foremost is the absence of a unified national training model (P 1) that would establish minimum content and organisational standards; as a result, education remains fragmented and heavily dependent on individual employers, leading to pronounced variability in learning opportunities and training quality (P 3, P 6), especially between public and private providers, where equal conditions for professional development are not guaranteed. Internal oversight of training is weak (P 2), and external control over institutions that offer specialist courses (P 9) is limited; no uniform system evaluates programme outputs, making it difficult to judge their real contribution to practice (P 10).

A serious gap also appears in adaptation processes: Slovakia lacks any state-defined system (P 4). Induction programmes differ widely, are often perfunctory or entirely absent, and thus may impair the readiness of newly hired staff. Similar deficiencies plague hospital-based inservice training for paramedics (P 5), whose quality depends solely on local workplaces and remains uncoordinated. Another neglected group within the EMS system, the 155 emergency-dispatch operators, receives no systematic educational support despite their crucial decision-making and communication roles (P 7). The continuing-education system itself still relies on credit accumulation without a clear focus on activity quality (P 8), encouraging formal box-ticking rather than clinically meaningful learning. Finally, insufficient financial and organisational support for external training opportunities (P 11) dampens motivation and restricts access to high-quality courses and professional events.

These findings underscore a legislative vacuum that affects adaptation, internal training and lifelong learning processes alike, producing significant inequities in Slovak paramedic education.

Code	Area	Identified deficiency	Implications for practice
P 1	Educational	Lack of a unified	Inconsistency in the quality, content and scope
	model	educational model	of education
P 2	Control	Weaker internal control	Insufficient monitoring of the effectiveness of
		mechanisms over education	educational activities; risk of formal
			fulfillment without real improvement of
D 0	D :		competencies.
P 3	Diversity of	Diversity of educational	Unequal access of employees to current
	activities	activities among employers	professional knowledge; different readiness to
D 4	Adamtatian	Look of systematic	deal with real situations in the field.
P4	Adaptation	Lack of systematic	unconsistent integration of newly nired
	processes	adaptation program	achieve independence in field practice
D 5	Hospital	Inconsistency of internal	Differences in the level of clinical training
13	environment	education in hospitals	depending on the workplace: absence of
	environment	education in nospitals	standardized bridging between academic
			education and practice.
P 6	State vs.	Significant diversity of	Inequalities in professional development
	private	conditions and content of	between state and private providers of EMS;
	sector	education between sectors	variability in the availability of modern forms
			of education.
P 7	Operations	Insufficient support for	Underestimation of the educational needs of
	centers EMS	education of emergency	operators; weakening of decision-making
		line operators 155	processes and the effectiveness of resource
			allocation in acute situations.
P 8	CPD system	Deficiencies in the system	Preference for passive forms of education with
		of continuous education	low efficiency; bypassing real professional
		(credits vs. quality)	training in favor of formal fulfillment of
DO	E 1	W/1	Pick of local of a factor of a second second
P 9	Educational	weak external control and	change of close criteria for accessing the
	organizations	institutions	quality of education providers
P 10	Quality of	Limited control of the	Failure to guarantee the required level of
1 10	programs	output quality of	knowledge and skills among graduates of
	programs	educational programs	educational activities: possible negative impact
		Programs	on the quality of healthcare provided.
P 11	External	Insufficient financial and	Limited opportunities to participate in
	activities	organizational support for	innovative courses, workshops and
		external educational	competitions; reduced motivation for
		activities	professional growth and acquisition of new
			competencies.

Chyba! V dokumentu není žádný text v zadaném stylu	.Table 2 - Identified defic	its arising from the practical
investigation of the issue (source	e: authors' own elaboratio	n).

These shortcomings constitute a systemic challenge whose resolution demands legislative, institutional and professional interventions in the education of emergency medical service personnel in the Slovak Republic.

Synthesis of key Findings

To establish clear priorities among the identified problem areas, an expert assessment of the education deficits was undertaken. The resulting heat-map positions each deficit along two axes: urgency, understood as the need for immediate action to halt further deterioration, and impact on quality, defined as the anticipated influence of a given area on the professional standard of training. Eight specialists—each with at least five years of experience in emergency medical services or EMS education—participated in a two-round Delphi process. In the first round they selected the principal problem areas from a predefined list that reflected the earlier analysis; in the second they scored each deficit from one (lowest) to five (highest) for both urgency and impact. Consensus was accepted when the inter-quartile range did not exceed one; any remaining disagreements were resolved through online discussion. The mean scores were then averaged across the two dimensions and plotted to produce the heat-map presented in Figure 1, a visual distillation of targeted expert judgement that indicates where reform efforts in Slovak paramedic education should be concentrated.



Figure 1 - Priority heat-map: urgency versus impact on quality (source: authors' own elaboration)

The analysis assigns the greatest priority to the adaptation process (T1). The lack of a statemandated induction framework creates wide disparities in the initial preparation of newly hired paramedics and compromises the most sensitive stage of care, namely the first patient contact. Although a credit system for continuing professional development (T5) is in place, genuine competence growth remains largely nominal. National clinical guidelines for prehospital interventions (T4) are still absent, leaving providers without a common evidence base. Marked heterogeneity in in-service training (T2) weakens the coherence of professional development and hampers the transfer of skills across regions. Educational quality control (T6) is virtually nonexistent, since no external audit mechanism assesses training programmes or certifies the competencies they produce. Whereas post-graduate support (T3) could have a substantial positive effect, its implementation depends on resource availability and strategic planning, making its urgency variable.

At the centre of these issues lies a legislative vacuum that affects adaptation, internal training and continuing education alike, producing substantial inequities across the Slovak EMS workforce. These deficits constitute the baseline for the systemic remedies proposed in the next chapter of this dissertation, while Table 3 summarises both the theoretical and practical shortcomings of the current system and their likely effects on clinical practice.

Code	Problem definition	Possible impacts of problems on practice	
1	Heterogeneity of educational activities – the scope and level of courses, workshops and drills vary with each EMS provider's culture and financial capacity.	Uneven crew preparedness; inconsistent intervention quality; limited staff mobility across regions or provider	
2	Missing adaptation training process – new employees undergo informal or only partial adaptation.	Slower integration of new employees, higher risk of errors in practice, insecurity of workers in crisis situations, reduced quality of care provided.	
3	Inconsistency of internal education in the hospital environment – internal courses focus on doctors and nurses, paramedics are often neglected.	Insufficient consideration of the specific needs of rescuers, reduced ability to respond effectively in multidisciplinary teams in emergency departments.	
4	Diversity between public and private emergency medical service providers – differences in technology, methodologies and work practices.	Inconsistent approach to education, impaired coordination and communication during joint interventions, different levels of patient safety depending on the founder.	
5	Insufficient support for emergency line operators – limited training opportunities, high workload.	Risk of inaccurate sorting, poor quality of communication during emergency calls, psychological burnout of operators, long-term reduced dispatching efficiency.	
6	Outdated legislation and insufficient regulations – they do not resonate with technological and methodological progress.	Outdated educational curricula, non-compliance with international standards, inhibition of innovations in education and practice, absence of modern forms of teaching (e-learning, simulations).	
7	Shortcomings in the continuing education system (credit system) – formal implementation, low quality of some courses.	Insufficient professional development, risk of formal approach without real improvement of professional level, loss of motivation of paramedics to participate in education.	
8	Insufficient control of educational institutions – limited evaluation criteria by the Ministry of Health of the Slovak Republic.	Variable quality of teaching, limited feedback for education providers, low transparency and control of the effectiveness of educational programs.	
9	Limited quality control of education in EMS providers – especially in the private sector.	Risk of undersized or outdated educational activities, deepening differences in the professional preparedness of rescue workers depending on the type of founder.	
10	Insufficient support for external educational activities – financial and organizational barriers to participation in professional events.	Poor access to current knowledge, limited professional growth, reduced employee motivation.	

Table **Chyba! V dokumentu není žádný text v zadaném stylu.**2 - Summary of the identified deficiencies in paramedic education (Source: authors' own elaboration).

Figure 2 presents a concise overview of the Slovak system for the preparation and education of paramedics, together with the problem areas identified in this study. The visualisation captures the key components of the legislative framework, the educational processes, and the stakeholders responsible for safeguarding paramedic competence.



Figure 2 - Visualization of the identified deficiencies in the training and education of EMS personnel (source: authors' own elaboration).

The legislative framework (beige blocks, left) comprises the pertinent statutes and ministerial decrees. Formal education (light-grey blocks, upper section) encompasses accredited secondary and tertiary programmes that confer professional qualifications to practise as a healthcare provider. In-service (internal) training (mid-grey blocks, centre) refers to activities organised by employers—the emergency medical service (EMS) providers themselves. External continuing education (purple block, lower left) covers the various forms of further training delivered outside the employer's organisation.

Critical weaknesses are highlighted by red cloud icons numbered 1-10, each representing a discrete deficiency within the respective subsystem. Contributing sub-issues are marked with **hexagonal symbols** carrying the letters **P** (practice) or **T** (theory). Along the right-hand margin, the diagram sketches the concept of **continuing professional development** across a five-year active career.

This visual schema functions as both an analytical and design tool for a comprehensive appraisal of Slovakia's current paramedic-training architecture. It identifies the loci at which improvements in quality and efficiency are most needed to enhance paramedic readiness and competence.

Discussion

The questionnaire survey showed that almost one-half of Slovak paramedics regard their professional preparation as merely average, while a further third consider it inadequate. This scepticism can be directly linked to the absence of a unified adaptation programme and to non-standardised in-service training. The highest levels of satisfaction were reported by respondents who have access to simulation-based training and to standardised clinical protocols—an observation that supports the WHO assertion that simulation-supported, continuous training lowers mortality in emergency conditions. The findings therefore confirm a close linkage between the degree of educational standardisation, the quality of training methods and the perceived readiness of emergency medical crews.

By combining a legal review, a large international sample and an expert panel, the study enhances internal validity and reduces the risk of a one-sided perspective. Triangulation of the three data sources led to the identification of the same five thematic deficits, underscoring the robustness of the results. External validity is partly limited by the cross-sectional nature of the data, which were collected within a defined time-window, and by the reliance on selfassessment, which may be affected by recall bias. Nevertheless, comparison with the work of Kučera et al. suggests that the identified problems are not confined to Slovakia but have a broader regional character.

The most acute systemic deficiency is the absence of a legislatively anchored adaptation framework, which results in uneven initial preparedness among new recruits. The importance of simulation is evidenced by a 0.8-point advantage (on a five-point scale) for respondents who regularly participate in simulation training. A lack of financial and organisational

incentives is directly reflected in lower attendance at external courses and poorer access to modern educational formats. In addition, the absence of external quality audits of in-service courses prevents an objective assessment of their true clinical value.

The principal limitation of the investigation is its cross-sectional design, which precludes inference of causality between educational quality and clinical outcomes. The self-report format may introduce subjective bias. Future work should therefore include longitudinal monitoring of clinical indicators before and after implementation of the recommended measures and experimental evaluation of the effect of a standardised adaptation programme on the competencies of newly appointed paramedics.

The proposed reform should be built on (i) a legislatively defined six-month mentored adaptation cycle; (ii) a nationally standardised annual in-house training plan that mandates a minimum number of simulation hours; (iii) a competence-oriented continuing professional development system subject to external audit; and (iv) grant and tax incentives for providers that offer external placements or innovative courses. Implementation of this model is expected to raise paramedic satisfaction, shorten decision-making times in the field and, most importantly, improve patient safety in pre-hospital emergency care.

Conclusions

The findings unequivocally demonstrate the need for a legislatively anchored, nationwide adaptation framework that equalises the initial competence of newly recruited paramedics. Any comprehensive reform must also incorporate standardised in-service training governed by minimum national learning standards, clearly defined training intervals and routine external audit. The current credit-driven model of continuing professional development should be transformed into a competence-based system centred on simulation, objective structured clinical examinations (OSCE), and systematic collection of clinical performance indicators.

National clinical guidelines for pre-hospital care must be developed—and regularly updated—in close collaboration with professional societies and emergency medical service (EMS) providers to ensure uniform, evidence-based interventions in the field. Effective implementation of these measures should be supported by financial and institutional incentives, notably targeted grant schemes and tax relief for providers that invest systematically in external placements and innovative training courses.

Full realisation of the proposed measures will enhance patient safety, shorten on-scene decision-making times and help Slovak pre-hospital emergency care meet international standards of quality and clinical outcomes.

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