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Training and Performance of Dental Assistants in Tunisia's Public Sector: A Nationwide Survey

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Abstract:
The role of the dental assistant is fundamental in modern dentistry, both in private practice and within public health facilities. In the public health context, dental assistants play a pivotal role in ensuring asepsis and promoting ergonomic practices, thereby contributing to the efficiency and safety of dental care delivery.

Objective: This study aimed to assess the knowledge and practical attitudes of dental assistants working in public health facilities in Tunisia.

Methods: A descriptive cross-sectional survey was conducted across multiple regions of Tunisia. Data were collected through a structured questionnaire administered to a representative sample of dental assistants employed in the public health sector.

Results: Findings revealed significant gaps in training and very low levels of knowledge regarding hygiene and asepsis (49.20%), dental unit maintenance (44.60%), instrument management and handling of dental biomaterials (12.30%), treatment of patients with infectious risk (35.40%), and four-handed dentistry (16.90%).

Keywords: dental assistant-Tunisia-asepsis-four-handed dentistry-training.

Introduction

According Wang LH et al (1) ,Taiwan's official regulations define a dental assistant as a person who supports dentists in clinical, surgical, and imaging tasks, as well as in instrument preparation and sterilization.

Dental assistants constitute an essential component of the oral healthcare workforce and play a critical role in ensuring the efficiency, safety, and quality of dental services. Their responsibilities extend beyond chairside assistance to include infection prevention and control, patient education, radiographic procedures, instrument management, and administrative support. As a result, the level and quality of their training directly influence clinical performance, patient satisfaction, and overall service delivery within dental care systems. (2)

Globally, the organization and training of dental assistants vary considerably across countries and healthcare settings. In many low- and middle-income countries, including those in North Africa, dental assistants often enter the workforce through heterogeneous training pathways, with limited access to standardized curricula or continuing professional development programs. (3) This lack of uniformity may lead to variations in competencies, role delineation, and performance.

Previous studies have emphasized that appropriate training and effective utilization of dental auxiliaries can significantly improve productivity, optimize workforce distribution, and enhance access to oral healthcare services. (2)

In Tunisia, the public oral healthcare sector relies heavily on dental assistants to support service delivery in hospitals and primary healthcare facilities. Despite their central role, there is limited nationwide evidence evaluating their training background, scope of practice, and perceived professional performance. The lack of formal training is a key factor underlying the evidence gap.

To date, training for dental assistant is not introduced yet in public universities. Private centers offers specific programs for dental assistants since 2019.before this time the stuff recuited for this function in both public and private sectors had nursing diplomas or other trainings.

Therefore, the aim of this study was to assess the training pathways and performance of dental assistants working in Tunisia’s public sector through a nationwide survey. By providing comprehensive national-level data, this research seeks to inform evidence-based recommendations for standardizing training, improving professional competencies, and enhancing the contribution of dental assistants to public oral healthcare delivery.

Methodology

A cross-sectional study among dental assistants was performed in Tunisia in 2016. This study covers the Greater Tunis area, as well as the regions of Nabeul, Sousse, Mahdia, Béja, Kairouan, Sfax, Gafsa, Tozeur, Kebili, and Gabes. This is due to a combination of factors, including logistical challenges, an inability to secure authorization, and in some cases, an explicit prohibition from department heads against surveying staff.

A questionnaire was used as the basis for our study including 36 questions divided into 5 sections.

The questionnaire (annexe 1) enquired five categories :

1. **Hygiene and Asepsis** (Q7-Q19)
2. **Maintenance of the Dental Unit** (Q20-Q24)
3. **Management of Patient with Infection Risk** (Q25-Q27)
4. **Instrumentation and Biomaterials** (Q28-Q30)
5. **Four-Handed Dentistry / Procedures** (Q31)

A score of 70% or higher of good answers about every category on the knowledge assessment was considered meeting the required standard.

Based on that, the staff will be classified into two levels: the first level includes those who meet the required standards and the second level includes those who do not.

For each stuff member, we calculate the percentage of correct answers in each category independently. The score of each category is calculated with the following formula:

Category Score (%) = (Number of Correct Answers in the Category / Total Number of Questions in the Category) * 100

Then we determined "Pass" or "Fail" for Each Category and we Compared each Category Score to the 70% threshold.

If Category_Score ≥ 70% → **Pass** / If Category_Score < 70% → **Fail**

Then we determined the Overall Level (Final Classification)

Check the results from this step for all categories.

- Level 1 (Meets Standards): The staff member has PASSED all categories.
  - *Condition:* Category_1_Score ≥ 70% AND Category_2_Score ≥ 70% AND ... AND Category_5_Score ≥ 70%
- Level 2 (Does Not Meet Standards): The staff member has FAILED at least one category.
  - *Condition:* Category_1_Score < 70% OR Category_2_Score < 70% OR ... OR Category_5_Score < 70%

→ We deduce a final formula Final Formula in a Nutshell: Overall_Level = IF (MIN (Category_1_Score, Category_2_Score, ..., Category_5_Score) >= 70, "Level 1 - Meets Standards", "Level 2 - Does Not Meet Standards")

Data collection and analysis were performed using IBM SPSS Statistics 19, and Microsoft Office Excel 2007 was used for graphical representation. Statistical tests such as Chi-square and Phi coefficient were employed to determine the significance and strength of relationships between variables (gender, region,level of education,training received,years of experience and level of knowledge), with a significance level set at $p = 0.05$.

Results

65 questionnaires were collected with a rate of answers is 67%. Demographic Characteristics of the Sample: Gender wise: 85% of the respondents females and 15% are males. 49% from Tunis Capitol, 12% from the center, 6% from the north, 11% from Sfax, and 22% from the south.

Related to the level of education: 78% of the personnel are nurses with a university degree, while 22% are workers with education not exceeding secondary level.

In terms of experience, 46% have less than 5 years of experience, 11% have between 5 and 10 years, 23% have between 10 and 20 years and 20% had more than 20 years of experience. These percentages indicate an increasing rate of recruitment of dental assistants in public sectors.

Only 42% of the staff has received training, while 58% have not (figure4). The proportion of trained nurses (47.06%) is notably higher than that of workers (21.43%), yet both remain below the halfway mark (figure5). About specific training: 54% of the trained staff have received training in hygiene and asepsis, 32% in instrumentation and dental biomaterials, and 14% in managing high-risk patients. No staff members have received training in dental unit maintenance or four-handed dentistry.(figure6)

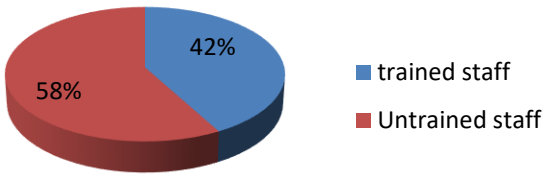

Figure 1: Training Received

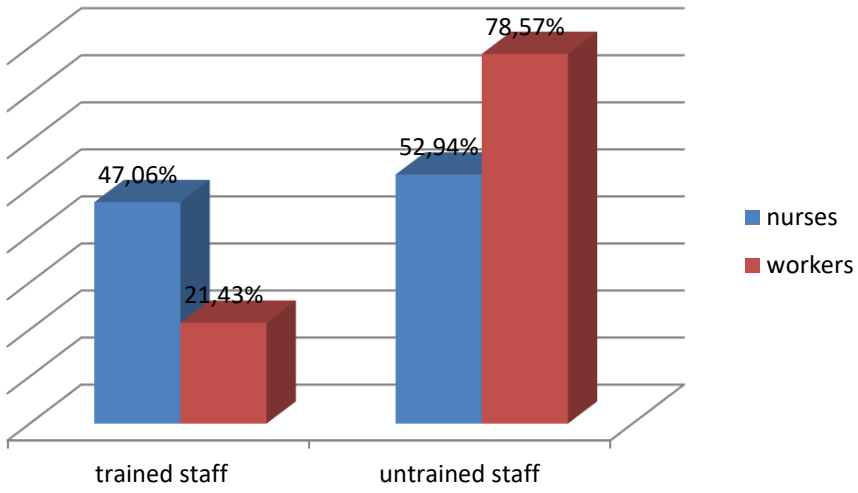

Figure 2: Training Received By Educational Level

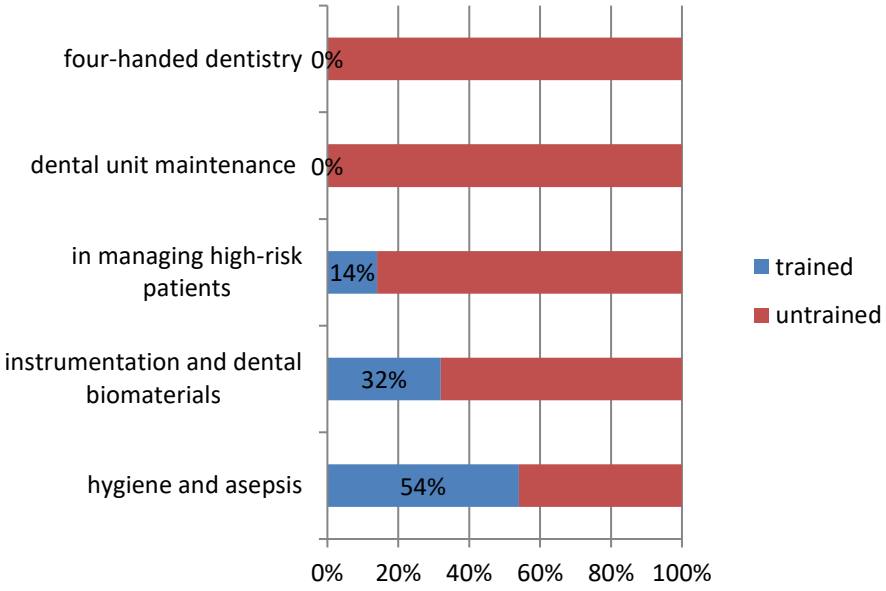

Figure 3 : areas of training

The study revealed very low levels of knowledge among dental assistants in areas such as hygiene and asepsis, maintenance of dental units, management of instruments, and handling of dental biomaterials, and care for patients with infectious risks.

We found that only 23% of staff has a level of general knowledge meeting our standards then the remaining 77%are unable to respond correctly to our survey.

The 1st level: “meets the standards”: the percentage of staff with this level of knowledge remains less than 50% for all categories. The percentage of staff with this satisfactory level of knowledge is found increased primarily in hygiene and asepsis with 49.20% then in maintenance of the dental unit with 44.60%, then the management of patient with infection risk with 35.40%.only 12.30% of personnel in instrumentation and biomaterials and 16.90%

in four-handed dentistry. The 2nd level: “does not meet standards”: notably increases in dental instrumentation and biomaterials with 87.70% of personal, and remains above 50% for other categories.(figure6)

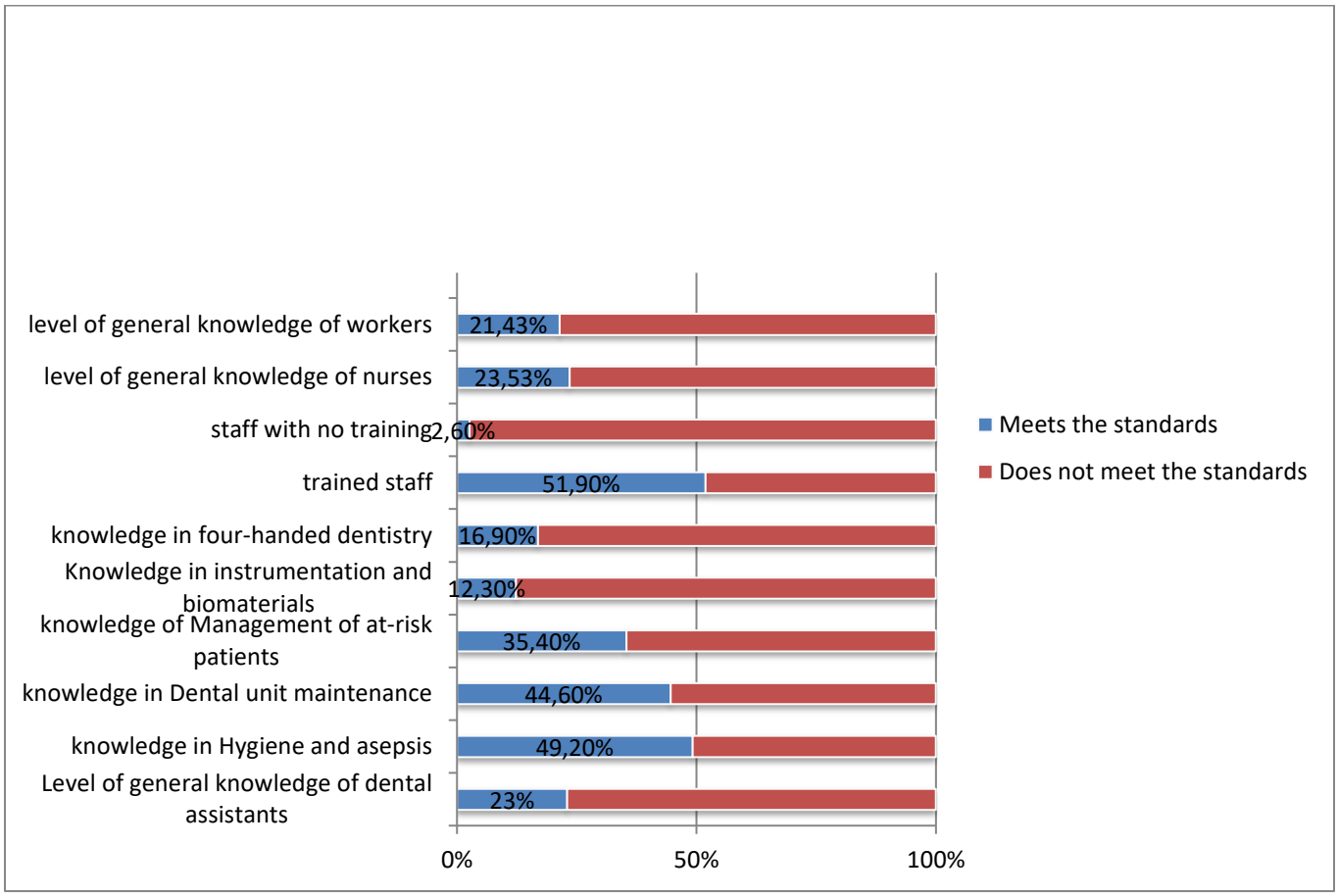

Figure 4 : Assessment of knowledge according different parameters

Related to the level of education: we didn’t notice a significative difference P=0.869.

We noted a statistically significant relationship (P: 0.000; Phi: 0.576) between training followed by staff and their general level of knowledge: the majority of untrained personnel (97.40%), have a level of knowledge that does not meet standards and only 2.60% of staff arrive to the appropriate level.

There is not a significant relationship between the general level of knowledge and the professional experience (P=0.3). There is a moderate significant relationship between the level of knowledge in maintenance of the dental unit (p=0.031; V=0.369) and the level of knowledge in four-handed dentistry (p=0.043; V=0.335) with the years of experience.

Discussion

The study aims to evaluate the level of knowledge of the staff working as dental assistants in the public sector in Tunisia about hygiene and asepsis, instrumentation, mangement of patients with risk and four-handed dentistry.

Wang LH et al (1) give an official definition of Taiwan's official regulations of a dental assistant who is a person who assists a dentist in the prevention, diagnosis, treatment of dental and oral diseases or the preparation, cleaning and disinfection of dental instruments, equipment, and materials, also his responsibilities includes assisting during surgery, helping in photography and oral dental imaging. (1)

Our study reveals a female majority, with 85% compared to only 15% of men. All the studies that surveyed dental assistants found that it is a female dominated profession. Almost half of the surveyed dental assistants reside in Tunis Capitol which is known for its high concentration of healthcare facilities compared to other regions.

The majority of the staff recruited in the public sector dental medicine service are nurses with a university degree, representing 78% of the personnel, compared to 22% of workers whose educational level does not exceed secondary school. Workers are more frequently recruited in first-level healthcare facilities compared to those in other healthcare levels.

A study realized in Saudi Arabia Al Jazairy YH et al (2) 83.7% of the participants were females, 10.2% of which had a Bachelor's degree in Dental Assisting, 13.5% had a Diploma in Dental Assisting, 10.6% had a Bachelor of Science in nursing and 61.4% had a dental degree obtained from the Philippine. From the initial group, 69.5% had years of experience <10.(4)

In Taiwan, Wang LH et al (1)affirm that since 1923 the training program of nurses contains special training for dental assistants. Despite this, Taiwan still lacks a mandatory, government-run certification system for dental assistants, thus training is often informal and occurs on the job.(1)

A study in 2021 in Pakistan, published by Mahdi SS et al(5) found that in only 7.14% had a diploma from a dental assistant program, although 34.30% had more than 5 years of practice

These findings are much lower than those observed in a study conducted in the same year in Bulgaria. The surveyed dental assistants reported varying years of experience: (31.48%) had up to 5 years of practice, (22.22%) had up to 10 years, (23.15%) had up to 20 years, (13.89%) had up to 30 years, and (9.26%) had over 30 years of experience in the field.(6)Concerning the type of education, 42.6% of dental assistants had a general medical education, while 32.4% had dental assistant education and 25% had non-medical education.(6)

In the USA, Kracher C et al (2) found that in 2017 most dental assistants underwent on-the-job training, while many dental assistants holding the Certified Dental Assistant (CDA) certification have completed a one- or two-year formal training program.

In Iran, Ghasemi H et al (7)conducted a study on a sample of dental assistants, between 65% of the participants reported to have less than 5 years of working experience, 56% of the dental

assistants had more than high school diploma, 68% had an education related to their job and 64% had job related certificate. In the same study, almost one third of the respondents' indicated getting usual training or courses on infection control at their dental practice.

In Tunisia, concerning training, the staff responsible for dental assistance begins their work without any theoretical training, relying only on the practical knowledge they gradually acquire through experience. However, we note a gap between theory and practice. Although the dental assistant profession may appear accessible without formal training in Tunisia (prior to 2017), data shows that training significantly influences the quality of practices. Notably, 51.9% those who did, achieved compliance with standards, compared to just 2.6% among untrained staff. This confirms that training reinforces technical skills (e.g., sterilization, radiography) and better practices (hygiene, risk management).

Also, there is a total lack of understanding and application of the "four-handed dentistry" concept among dental assistants. The Four-handed dentistry is a highly efficient team-based approach where the dentist and dental assistant work in a coordinated, pre-planned manner to optimize dental procedures. Introduced in 1960 and later summarized by Glene Robinson in 1968, this method emphasizes the critical role of a trained chairside assistant, who actively supports the dentist by handling non-clinical tasks, ensuring proper instrument transfer, and maintaining an organized workflow. (8) In Bulgaria ,Yaneva-Ribagina K et al (6) reported a 100% of dental assistants assisted in the treatment process but only 4.63% of them performed manipulations in the patient's mouth.

About managing risk patients, we found that 35.40% of the surveyed personnel had a score that meets the standards. Considering that dental assistants are frequently responsible for IPC(infection prevention and control) procedures in dental practices(7) the significant majority (64.60%) did not meet the required standards for a critical safety protocol. Almost the same percentage was found in the study conducted by Ghasemi et al. where over 60% of dental assistants reported no related on-the-job training, the core issue appears to be a systemic gap in continuous, standardized infection control (IPC) education for dental personnel.(7) A study from Pakistan revealed a percentage of 11.4%of assistants always labeled critical instruments with batch control info before sterilization, which indicates significant lapses in vital traceability and safety procedures, although 91.4% of them reported maintaining and refreshing their knowledge annually.(5) These percentage can explain the main cause of the low compliance which is a systemic failure in translating knowledge into consistent and correct practice. Inconsistent instrument processing and hand hygiene directly increase cross-infection risk for all patients, especially high-risk ones.

In 2024,a systematic review (9) establishes that adherence to IPC practices like hand hygiene, PPE use, and isolation is shaped by the interconnected triad of knowledge, individual, and environmental factors(9)his means that gaps in training, individual stress or perceptions, and systemic issues like resource shortages or unsupportive workplace culture all contribute to suboptimal adherence. Therefore, a low compliance rate, such as the 35.4% found in our study, likely reflects not just a lack of awareness but a breakdown in the broader system. Addressing these multifaceted behavioral influences is essential for improving infection

control outcomes in dental practice.(9) We will discuss the result using the three factors from the systematic review:

First, the Knowledge-Oriented Factor: Some tasks (e.g., "I don't know" for compressor draining) directly indicate a training gap. The correct procedures must be taught explicitly. Second, the Environment-Oriented Factor: Choosing easy but incorrect options (e.g., "I leave the unit without disinfecting" at day's end) suggests a workplace culture or time pressure that undermines protocol. Lack of clear checklists or accountability can be a factor. And third, the Person-Oriented Factor: Opting for convenience ("Only when it is functioning abnormally" for lubrication) shows how individual habits and risk perception override knowledge.

Our findings show that only 44.60% of surveyed personnel meet the standards for dental unit maintenance is a critical and very specific data point for our study. It highlights a significant, tangible gap in infection control that perfectly complements the knowledge-practice gap identified in this article by Javaiid et al. identified 70.2% awareness of waterline contamination risk, but no specific compliance data was reported.(10) So our 44.60% figure is a robust finding. It moves the discussion from abstract "awareness" to concrete "action failure". We can argue that improving this compliance requires moving beyond simple training to implementing structured systems (e.g., mandatory daily checklists, clear responsibility assignments, and practical hands-on demonstrations) to overcome the behavioral and environmental barriers identified.

Our finding of only 16.9% compliance in four-handed dentistry is critically low. The literature review explicitly identifies four-handed dentistry as a recommended technique to reduce cross-contamination risk and enhance clinical efficiency, making its standardized application essential.(11)

The article clarifies that dental assisting has historically evolved with widely varying and often non-existent state-level requirements for formal training and credentialing. So, the discussion must shift from blaming individual practice to advocating for the foundational reform of the profession itself through the implementation of standardized, mandatory education and national regulation.

Conclusion:

The success of dental treatment is the result of teamwork in which the assistant plays a capital and essential role in the course of the treatment session.

This study, conducted in Tunisia in 2017, shows a level not meeting standards in hygiene and asepsis, dental unit maintenance, infection risk, dental instrumentation and biomaterials, and chairside operative assistance, as well as a total lack of knowledge of the four-handed work concept.

Our study reveals deficiencies in theoretical and practical knowledge that impact the performance of personnel in public sector dental medicine services. Nearly half of the personnel (46%) attend continuing education courses to improve; however, the programs offered to dental assistants do not meet the specific needs of this field.

This study should be followed by more recent research to reassess the situation of dental assistants in Tunisia's public sector, identify remaining gaps, and develop an action plan to address them.

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Annexe :

Evaluation Survey for Dental Assistants

Staff Identification

1. Region:
◯ Greater Tunis
◯ North
◯ Central
◯ Sfax
◯ South

2. Healthcare Level of the Facility:
◯ Primary Care
◯ Secondary Care
◯ Tertiary Care

3. Gender:
◯ Male
◯ Female

4. Level of Education:
◯ Nurse
◯ Dental Technician / Assistant
(Note: "Ouvrier" was translated to a more relevant role in a dental context.)

5. Your years of experience is:
◯ Less than 5 years
◯ Between 5 and 10 years
◯ Between 10 and 20 years
◯ More than 20 years

6. Have you already received training in dental assistance?
◯ Yes
◯ No

If yes, in what area(s)?
◯ Hygiene and asepsis
◯ Maintenance of the dental unit
◯ Instrumentation and dental biomaterials
◯ Management of at-risk patients
◯ Operatory assistance at the chairside

Hygiene and Asepsis

7. The steps you take to sterilize instruments are:

1. Waste sorting

2. Decontamination
3. Mechanical washing
4. Rinsing
5. Drying
6. Packaging
7. Sterilization
8. Checking the sterile state
9. Storage

8. The duration of decontamination is:
◯ Less than 15 minutes
◯ 15 minutes
◯ More than 15 minutes
◯ I don't know

9. Mechanical washing by hand is done:
◯ While wearing gloves
◯ Without wearing gloves

10. Drying of the instruments:
◯ is done with wool towels
◯ is done with single-use towels
◯ is done by leaving them in the open air
◯ is not necessary

11. The sterilization methods used are:
◯ Moist heat sterilization (Autoclave)
◯ Dry heat sterilization (Oven)
◯ Chemical vapor sterilization (Chemiclave)
◯ Sterilization with ether

12. Placing the material in the autoclave is done:
◯ Plastic side against plastic side and paper side against paper side
◯ Any which way

13. Storage is done:
◯ In clean and dry places
◯ Anywhere

14. The material is considered non-sterile when:
◯ The pouch is hot
◯ The pouch is damp
◯ The pouch is torn, pierced by the instrument
◯ The packaging is not intact
◯ The chemical indicator strip does not change color
◯ The chemical indicator strip changes color
(Note: This was split from the original ambiguous line for clarity.)
◯ The shelf life of the sterile material exceeds 2 months

15. The water used in the autoclave is:
◯ Distilled water
◯ Tap water

◯ Mineral water
◯ Waste water

16. Between two patients:
You change:
◯ The examination tray
◯ The saliva ejector / suction tip
◯ The surgical drape
◯ The high-volume suction tip / evacuator tip
◯ Gloves

17. Among these materials, which are single-use?
◯ Burs
◯ Files
◯ Scalpel blades
◯ Broaches (for endodontics)
◯ Lentulo spiral fillers
◯ Irrigation syringes (containing NaOCl / EDTA)
◯ Suture needles
◯ Anesthetic needles

18. You dispose of the needle in:
◯ The regular trash
◯ A specific sharps container

19. If you run out of trays:
◯ You rinse them with water and reuse them
◯ You disinfect them with a detergent or with alcohol
◯ You proceed with another sterilization cycle
◯ You postpone the appointment

Dental Unit Maintenance

20. Lubrication of the high-speed handpiece (turbine) is performed:
◯ In the morning
◯ At the end of the day
◯ Only when it is functioning abnormally
◯ Once a week

21. Draining the compressor is done:
◯ Every day
◯ Once a week
◯ Every two weeks
◯ The compressor is self-draining
◯ I don't know

22. Between two patients:
You disinfect:
◯ High-speed handpiece / Low-speed handpiece (contra-angle)
◯ Air/Water syringe tip
◯ Headrest

◯ Spittoon / Cuspidor
◯ Tray table
◯ Control panel

23. At the end of the day:
◯ I disinfect the entire dental unit
◯ I detach the handpieces (turbine and contra-angle) and leave the clinic
◯ I leave the unit without disinfecting it

24. If the operating light (scialytic) no longer works:
◯ I call the technical service for repair
◯ I try to fix it myself
◯ We use a smartphone flashlight
◯ We work without operating light

Precautions for At-Risk Patients

25. Vaccination Status:
◯ **Hepatitis B:** Complete - Incomplete
◯ **Tetanus**
◯ **Tuberculosis**
◯ **Influenza (Flu)**

Since when: ……..

26. When dealing with a patient with active viral hepatitis B/C:
◯ They are seen first
◯ They are seen last
◯ They are seen according to their appointment order
◯ Their appointment should be postponed

27. After treating a patient with viral hepatitis, the instruments:
◯ Will be treated in the conventional manner
◯ Must go through 2 sterilization cycles
◯ Must be thrown in the regular trash

Knowledge of Instrumentation and Biomaterials

28. Instrument Identification

- **The Examination Tray**
  ◯ Mouth mirror
  ◯ Explorer / Probe
  ◯ Tweezers
  ◯ Spoon excavator
  ◯ Mouth spatula
- **The Amalgam (Filling) Tray**
  ◯ Amalgam carrier

◯ Condenser / Plugger
◯ Burnisher
◯ Cleoid-Discoid carver
◯ Modeling instrument: PKT

- **The Composite Resin Tray**

◯ Phosphoric acid (Etchant)
◯ Bonding agent (Adhesive)
◯ Shade guide
◯ Composite resin
◯ Abrasive strip
◯ UV Light / Curing light
◯ Finishing disc

- **Tray for Simple Extraction:**

◯ Periotome / Syndesmotome
◯ Elevators
◯ Forceps
◯ Curettes
◯ Gauze

- **Tray for Initial Periodontal Therapy**

◯ Periodontal probe
◯ Scalers (Sickle)
◯ Periodontal curette
◯ Ultrasonic scaler
◯ Polishing paste
◯ Polishing cup/brush

- **Matrix System:**

◯ Matrix holder / Retainer
◯ Matrix band
◯ Interdental wedge

- **Handling of the Matrix Holder:**

◯ Correct
◯ Incorrect

- **Instruments used in Prosthodontics**

◯ Impression tray
◯ Articulator
◯ Crown remover
◯ Handpiece

29. Handling of Different Biomaterials

- **Zinc Oxide Eugenol (ZOE)**

- **Presentation:**

◯ Powder + Liquid
◯ Paste / Paste (Two-paste system)
◯ Pre-dosed capsule
◯ Ready-to-use paste

- **Mixing Pad:**

◯ Glass slab
◯ Paper pad

◯ Sterilization pouch
◯ Other: ……

- **Consistency: According to the use**

▪ **Provisional (Temporary) Crown:**
◯ Hard
◯ Creamy

▪ **Root Canal Obturation:**
◯ Hard

◯ Creamy

- **Glass Ionomer Cement (GIC)**

- **Presentation:**
◯ Powder + Liquid
◯ Paste / Paste
◯ Pre-dosed capsule
◯ Other: ……

- **Mixing Pad:**
◯ Glass slab
◯ Paper pad
◯ Any surface

- **Mixing Time:**
◯ Less than 30 seconds *(Note: "5 minutes" is unrealistic; this has been corrected to a standard time.)*
◯ 30 seconds
◯ 1 minute

- **Amalgam**
◯ Is supplied in a capsule to be triturated (mixed)
◯ Is supplied as a powder and liquid
◯ It must be squeezed (condensed) immediately after trituration

- **Trituration Time:**
◯ 5ⓢ 8ⓢ 10ⓢ 15 s

- **Amalgam waste is:**
◯ Thrown in the regular trash
◯ Put down the sink
◯ Placed in a specific container (for hazardous waste)

- **Composite Resin**

- **Its storage is done:**
◯ At room temperature
◯ In a refrigerator (cold)

- **During its handling, it risks hardening under the effect of:**
◯ The light from the operating light (scialytic)
◯ The light from the lamp if the syringe is not closed
◯ Air

- **Light emitted by the UV/LED curing light:**
◯ Is a natural light
◯ Presents a danger to our eyes
◯ Presents no danger

- **Calcium Hydroxide (CaOH2)**

- **Presentation:**
  - ◯ Powder + Liquid
  - ◯ Paste / Paste
  - ◯ Pre-dosed capsule
  - ◯ Ready-to-use paste
- **Mixing Pad:**
  - ◯ Glass slab
  - ◯ Paper pad
  - ◯ Sterilization pouch
  - ◯ Other: ……

30. Among these biomaterials, which ones are you able to identify?

- Anesthetic with vasoconstrictor
- Anesthetic without vasoconstrictor
- Endotine
- Pulparthrol
- Liquid Eugenol
- Chlorhexidine
- Cavit
- Cémavit
- Pulpéryl
- **NaOCl**
- **H_2O_2**
- **EDTA Largal**
- **Grinazol**
- **Détartrine**

31. According to the correct chronology, the assistant must transfer:

- **During a simple extraction:**
  - ◯ Chlorhexidine (for pre-operative rinse or disinfection)
  - ◯ Anesthetic syringe
  - ◯ Periotome (Syndesmotome)
  - ◯ Elevator
  - ◯ Forceps (Davier)
  - ◯ Curette
  - ◯ Gauze (Compresse)
- **During a root canal obturation (endodontic filling):**
  - ◯ Paper points (Pointe absorbante)
  - ◯ Sealer (Root canal cement)
  - ◯ Adapted gutta-percha cones
  - ◯ Gutta cutter (or heated instrument)
  - ◯ Spreaders/Pluggers (MOCP)
- **During a Class II coronal restoration (e.g., with amalgam):**
  - ◯ Matrix system (for isolation and shaping)
  - ◯ Loaded amalgam carrier
  - ◯ Condenser (Plugger)

◯ PKT (or other carving instrument)
◯ Burnisher

Professional Motivation

32. You find your work:
◯ Easy, anyone can do it
◯ Difficult at the beginning, but it's becoming clearer and clearer
◯ Difficult on all fronts, I want to change jobs

33. Do you think your training/diploma was useful for this job?
◯ Yes, absolutely
◯ Yes, in part
◯ No, no relation between the two

34. Do you think that a formal training / a university degree in dental assistance would be more reliable for this job?
◯ Yes
◯ No

35. The Ministry of Health is organizing a training session for you:
◯ I will go, it will improve my performance
◯ I will go, I need the certificate for promotion (a higher grade/rank)
◯ I will not go, it's not interesting

36. When the dentist makes a remark, your reaction will be:
◯ I thank them, it's better that way
◯ I ask "Why?" (to understand the reason)
◯ I think "That's not true, the way I always do it is correct"
◯ I ignore the remark