Assertives vs. Non-Assertives

It is imperative that when we speak with our patients, we first understand ourselves and secondly, we understand them.

If you have studied DISC and Values reports, you realize that there are many different types of people who behave in many different ways. We act differently when we are calm and balanced vs. when we are stressed. We are all moved, motivated and inspired into action through different values and other factors.

One aspect of our DISC and Values is how **assertive** or **non-assertive** we are when we communicate with our patients. It is important to realize that as with all of the different aspects of behavior, we all have our strengths and weaknesses. The purpose of this article is to examine the difference between this one aspect of behavior and how it affects our communications with our patients, especially during the consult/examination, R.O.F. and daily interactions. For the sake of this article I will discuss the polar ends of the assertives and the non-assertives; of course, you are probably somewhere in between.

The **non-assertives** may be low D's, High I's, High S's, High C's or any combination of the above. The low D is the dominant factor. These people may be seen as easy going, peaceful, unassuming, humble and even meek. Above all else these people want to be liked by other people and they want to be seen as a good, honest and truthful person. They are sensitive to rejection and combined with the desire to be liked; these people usually downplay the seriousness of their patient's condition. They error on the side of telling the patient not to worry, that things are going to be ok. The doctor most often does not tell the patient the *truth* about how much care they need and how much it is going to cost. They are evasive and even cheery during the examination and R.O.F., the last thing they want is to use any of those "patient scare" tactics that many of the other doctor's use.

In other words, the non-assertive doctor most often not only understates the seriousness of the case, but they don't tell the patient how much care they really need to get the condition corrected. The doctor feels good about the encounter because the patient likes them for under stating the condition, but then later the doctor is frustrated that none of his/her patients ever follow through with their recommendations.

Of course the problem with this is that patients don't realize the seriousness of their problem, so when it comes time to tell the patient how much care they need, even if the doctor does tell the patient how much care they are going to need during the R.O.F., the patient just doesn't

realize how important it is to get the problem corrected and they just don't follow through. So, if the non-assertive doctor does not get a handle on this behavioral aspect of themselves, they are usually very ineffective when it comes to getting patients to follow their recommendations.

The **assertives** on the other hand may be high D's, high or low I's, low S's, high or low C's or any combination of the above. Again, the high D is the dominant factor. These people may be seen as ambitious, forceful, direct, decisive, independent, challenging and aggressive. Above all else these people want control and compliance. They usually believe that everyone likes them and that everyone absolutely "buys" everything they say. "It's my way or the highway." These people can be abrasive and very difficult to deal with. The only problem is they are the only ones who don't know it.

When it comes to consultation/examinations and R.O.F.'s assertives may error on the side of overstating the seriousness of the patient's problem, they may be prone to using "patient scare" tactics as they are "truly in the patients best interests." They will often times use persuasion and high-pressure sales techniques to get the patient to do what they want them to do, as they love the conquest.

Patients will often times sign up for care only to go home and have "buyer's remorse." Remember that no one likes to be sold, controlled or coerced; especially when it comes to health care. The assertive doctor will be very pleased with themselves when the patient leaves. The doctor will be sure that they did such a great job, that they "sold" the patient, and that the patient totally "got it" and is absolutely going to follow through with care. They are usually shocked when the patient decides to cancel care, and the doctor rarely thinks that they had anything to do with it. They are not as sensitive to rejection; in fact, they rarely think it has anything to do with them. As far as the assertive doctor is concerned, it is the patient, they are just clueless, ignorant imbeciles and the assertives move on to the next patient like a bull in a china shop.

Without a better understanding of themselves the assertives can be naturally offensive, and they can overwhelm their patients with heavy handed sales techniques and huge cases that cost a fortune. "After all, the patient is right in the palm of my hand, they love me, and they totally get the importance of care…"

Both styles of doctors see the other side as a big problem in the profession. The non-assertives think the assertives are ruining our profession because they are overstating the seriousness of patient's problems, over recommending care and driving patients away from your care with patient scare tactics.

The assertives feel the non-assertives are just wimps that have absolutely no idea whatever it is that you do or what your profession is, is all about. They feel that they are totally doing the patient a disservice by not telling them the truth of how serious the problem is and the truth about how much care they really need to correct the underlying problems.

From my perspective they are both right! Both doctors are doing the patient a grave injustice. The fact of the matter is patients need to know the truth about how serious their problem is, the consequences of their choices are, and how much care they need; nothing more and nothing less. They want to know what is wrong, can they be helped, how long will it take, and what will it cost. Remember, it is not about you, the doctor; it is about them, the patient. The more we can learn about ourselves, the less we have to be shackled by our behavioral styles.

On the flip side of the coin the non-assertives have some really great qualities. Most everyone loves the non-assertives, even if they try, they will rarely offend patients. People trust non-assertives, so if you are a non-assertive, all you have to do is tell the truth. Tell your patients the truth and the consequences of their actions and then simply give them choices and trust that they will make the best decision that is in their best interest.

Assertives also have great qualities. They are confident and impressive; they have a certain sense of magnetism that draws people to them. They don't have thin skin and can deal with the rejection of everyday practice easier than others. Again, all they have to do is tell the truth and not embellish it for the sake of effects and shock value.

When it comes to patient scare vs. patient care both the assertive and non-assertive doctor must first know themselves and then go towards the middle ground, telling their patients the truth and consequences, and offering love and choices. We can be **assertive** without being **aggressive**. Aggressive means you are getting your needs met at someone else's expense. Assertive means you are able to have your needs met and being willing to ask for it. Whether you are a non-assertive or an assertive you do NEED to communicate the truth to your patients in a loving way. You need to offer them real choices and tell them the truth and consequences of their actions. There is a way to get "your needs met" and meet your patients needs in a totally professional and ethical way!

In our communications program we examine every possible interaction you may have with your patients. We study the consultation/examination, R.O.F., daily interactions, re-exams and re-reports, and how to deal with the difficult questions, statements and patients.

My experience is we must first get a better idea of who we are and what we offer as optimal health doctors. We then can examine how to best communicate what it is we do with our patients. One of my long-time beliefs is; if the patients knew what you knew, they would most likely follow your recommendations. By studying each interaction, you have with your patients you won't have to get caught flat footed and let your particular behavioral style, i.e. assertive or non-assertive, get in the way of your communications.

In my D.I.S.C. behavioral analysis course we examine every aspect of different behavioral styles and how to open the doors to communication with everyone we meet. Once you have a better understanding of who you are and your behavioral style we study how to communicate with others, i.e. how do you deal with an assertive or non-assertive patient?