I am writing this essay as a memorial to my father and, as I prepare to retire from clinical practice, to look back over the development of the model from consulting to teaching and learning.

Henry Middleton (1923–2008) was a chartered engineer and a stress supervisor at Rolls-Royce Aero Engines in Derby. He devised a theory, compatible with Christian teaching, based on the law of Conservation of Energy applied to human behaviour. Not having an academic base and, in any case, not seeking personal fame, he had his work published privately. He used to say that the work was for his children and grandchildren, if any of them wanted to develop it.

Having become a trainer, and later a course organiser, I found myself grappling with models of the consultation and their application to teaching. There were many models and it was easy to be confused by some of the jargon. Perhaps the most accessible was the old model of Byrne and Long, based on audiotapes of consultations. It seemed that the source of the majority of problems was not discovering the reason for the patient’s attendance. Audiotapes were superseded by videos and Pendleton’s team elaborated the problem to include the patient’s ideas, concerns, and expectations (ICE). Nevertheless, although many candidates for MRCGP were able to memorise Pendleton’s seven tasks, some of the examiners felt that they had difficulty translating them into practice. In short, their consultations remained relatively doctor-centred.

It was very clear that ignoring the patient’s concerns led to disastrous consultations, but less clear why it happened so often, given the incentive for doctors to avoid trouble. My father and I must have had many conversations on this subject, on which he brought to bear his perspective as an engineer. He used to ask me ‘which component of the system needs the grease?’ I began to realise (or perhaps he told me) that doctors’ self-imposed tasks were often too numerous and weighty to allow patients much of a look in, even having expanded the time from 6 to 10 minutes.

Both parties to the consultation were arriving with a great deal of baggage (which I called ‘agendas’ in my 1989 model). There was obviously conflict or disharmony between the doctor’s and the patient’s agendas, which often led to the latter being suppressed, resulting in reduced cooperation or compliance. This, said my father, was where the grease was needed. Somewhere between the outcome and the two agendas, there had to be an enabling process. This was where the professional skills of the doctor (and perhaps those of the patient) should be employed: these skills would form the connecting link between the agendas and the final outcome, the negotiated plan. Effective negotiation would minimise conflict, maximise efficiency and concordance.

The new model had two eyes (the agendas), a nose (skills) and a mouth (negotiated plan). Drawing a circle round the whole and boxes round the components made it recognisable as the ‘face’, a name that stuck.

In what was known as ‘Trent’, now East Midlands Deanery, we trainers set about trying to apply the grease. It seemed to work better if we gave priority to understanding the patient’s concerns and working with them, often at the expense of those of the doctor. Patients seemed to accept the parts of the doctor’s agenda that were shown to be relevant to their own concerns, for example, the organisational issues might include the management of chronic problems or identification of risk factors. So the negotiation skills required were similar to those of the salesman. To properly understand the standpoint of a patient (or client), we found it necessary to extract not only the list (issues), but also the underlying thoughts (ICE) and the reasoning behind them (ICER). In ‘Trent’, ICER is cooler than ICE (Figure 1). The ‘Face’ model became a familiar feature of trainers’ courses on consultation skills in the deanery and the grease, or negotiation component in particular, began to turn up everywhere. Coincidentally, the model was

---

**Figure 1 The ‘Face’ Model.**
even adopted by a group of GP teachers in Trento, Northern Italy. Eventually I had the great privilege of delivering workshops, with simultaneous translation, on video recordings of consultations in Italian. The non-verbal communication proved invaluable in deciding where to stop the tape, although, in the far north of Italy, there is less of it than you might imagine.

Local trainers’ courses included a programme for would-be trainers, which is where the ‘face’ model found another application. There is a strong parallel between consulting and teaching: learners are particularly motivated by material they perceive as relevant to their needs; they tend to switch off when teachers appear to be following their own agendas. It may be true, to some extent, that learners have ‘wants’ and teachers know what they really need, but the skill lies in selling the curriculum and showing relevance to the concerns of the individual. Hence the negotiated teaching plan is likely to be more effective.

The ‘face’ model, in generic form (A’s agenda and B’s agenda), can apply to any communication situation, at least with a little modification. Sometimes there is an extra party in the consultation: Fred (A), Fred’s wife (B), and the doctor (C). So we have the monster with three eyes: three agendas for the professional to reconcile. It is more difficult, but you ignore Fred’s wife at your peril! Give her space to voice her concerns and the task is likely to be easier. In recent times it has often seemed as though the computer is a third person in the consultation; it certainly has a heavy agenda, in terms of templates demanding the doctor’s attention. A group is an even more scary monster with many eyes. Keeping track of and achieving a compromise between all those agendas is a major challenge for course organisers or other group facilitators. I found the ‘face’ model helpful, as a new course organiser, in understanding how groups work. Groups exist to share agendas. It needs plenty of grease to make it work, which is where the leader’s skills come in. Everyone must have their say and the plan must be explicit (on the flip chart) and, of course, negotiated. These applications of the model eventually formed the basis of a book on communication in the primary care team.²

I believed that use of the ‘face’ model in training would lead to more harmonious and more efficient consultations and, not being satisfied with anecdotal evidence, set out on the research pathway. If patients were enabled to write down their concerns and to share them with their doctors (using a ‘patient’s agenda form’), it seemed likely that their agendas would be better recognised and that outcomes would be improved. The major stumbling block appeared to be doctors’ negative attitudes to written ‘lists’, but I planned to overcome this, for the doctor volunteers, by an educational workshop intervention using simulated patients with agenda forms. My father continued to show an interest, wearing his engineer-philosopher’s hat, in the design of the research study. I am also grateful to Bob McKinley, who was my MD supervisor and all the GPs in Trent who took part in the study, not to mention the RCGP for awarding me a research training grant. The results of the study showed that the use of an agenda form by the patient, or attendance by the doctor at an educational workshop, resulted in the doctors identifying more problems in consultations with proportionately longer surgery duration and small increases in patient satisfaction.² Qualitative analysis of the forms confirmed the multilayered nature of patients’ agendas, including the reasoning behind the ideas that is, ‘ICER’.³ Of course, research always raises more questions, but the increased complexity of consultations was recently recognised in my own practice by increasing appointment times from 10 to 12 minutes.

The ‘face’ model does seem to capture the dynamic of the consultation, in terms of forces acting which need to be reconciled. Moreover, the concepts, of two agendas (or more) linked by communication skills to a negotiated outcome, are easy to remember and apply to any situation where communication is involved. I know that my father was happy that his ideas on conservation of energy and appropriate administration of ‘the grease’ had contributed to the model, and I am happy to acknowledge that influence. Although the model is not as widely known as, say, Pendleton or Neighbour,⁴ I think that the principles of respecting others’ agendas and negotiating outcomes have become established in the national curriculum. Conflict is a waste of time and energy. Pursuit of shared goals is the key to successful consulting and teaching. My father would also have contended that it is vital to international relations and the solution of global problems.

John Middleton

REFERENCES


DOI: 10.3399/bjgp09X394978