## Six *A*s model of counseling in obesity

In our *CMAJ* article,[1] my coauthors and I presented a 5 *A*s model that was slightly different from the modified 5 *A*s discussed by Vallis et al in the January issue of *Canadian Family Physician*.[2]

Because there is strong evidence that providing follow-up with treating physicians or other health care professionals is associated with better maintenance of behaviour change,[3-5] we have included *arrange for follow-up* as a separate step. We should consider that arranging for follow-up with other health care providers is not always a simple task, especially with patients who have limited financial resources and no private medical insurance. For example, arranging for follow-up with a dietitian or an exercise specialist needs to be negotiated and mutually agreed upon with these patients, as they are not always ready to pay for such services. Further, when you must arrange follow-up with other medical specialists, this should be well explained to the patients, as it might generate various emotions and other issues. Even arranging the frequency of follow-up with treating physicians should be negotiated and mutually agreed upon; some patients require more frequent follow-up than others and this should be clearly discussed with them.

For these reasons, I emphasize adding *arrange* as an important separate step to the 5 *A*s in the article by Vallis et al.[2] Recently, after discussion with obesity specialists and reviewing the medical literature, I decided to reorganize the 5 *A*s model as follows.[6]

- Ask for permission to discuss weight and explore readiness for change, as this is essential for success; then use motivational interviewing to move patients along the stages of change.
- Assess for obesity and its related health risks; for the potential causes and risk factors of obesity; and for nutrition, physical activity, psychosocial, economic, and environmental factors.
- Advise the patient on obesity and its associated health risks that can be improved with good lifestyle habits, with or without weight loss; discuss improving health and well-being, not just looking at the scale; and discuss treatment options.
- Agree on realistic, modest, and achievable weight-loss goals to help maintain motivation, and agree on reducing negative lifestyle behaviour and promoting positive behaviour.
- Assist patients to overcome identified barriers to weight management, provide self-help materials and resources, help patients identify strategies to improve adherence, and reward specific behaviour to increase motivation (not with food).
- Arrange follow-up with treating physicians and other health care providers when necessary. Considering the chronic nature of obesity, long-term follow-up is essential. Negotiate and agree on follow-up with the patient, as this is essential for success.

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**Competing interests**
None declared

**References**


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## *Response*

Dr Plourde has suggested that the modified 5 *A*s for obesity counseling in primary care[1] be expanded to include a sixth *A*: *arrange*. He nicely justifies this suggestion by illustrating how assisting patients to navigate emotional and practical issues of seeking supportive resources over time is a substantial clinical task in itself. Dr Plourde has also explicitly demonstrated how *arrange* can be appended to the 5 *A*s framework that we outlined. Our model incorporated *arrange* within the *assist* function, but we appreciate this spirit of collaboration and would heartily endorse Dr Plourde's suggestion. The purpose of tools such as these is to guide the busy practitioner through the somewhat confusing realm of navigating behaviour change in the real world. Thank you, Dr Plourde.

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