ORIGINAL RESEARCH

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Physician Attitudes on the Status, Value, and Future of Board Certification in Lifestyle Medicine

Abstract: *Objective: To assess physician attitudes on the status, value, and future of board certification in lifestyle medicine (LM). Study design: Cross-sectional survey of physician members of the American College of LM. Methods: A 49-item, web-based survey with a 5-point Likert response scale. Results: The 351 respondents did not differ significantly from the eligible sample of 6334 members regarding gender (68% female), country of residence (88% U.S), or census region, but did include more ABLM diplomates (63% vs 22%). Certification by ABLM was considered a source of personal pride (95% agree or strongly agree) that could help in marketing clinical services (85%) and potentially increase job opportunities (60%). Certification by ABLM is sufficient for certification needs (67%), but there was interest (65%) in LM becoming a member board of the American Board of Medical Specialties (ABMS) as an aspirational goal (48%). Few respondents (22%) practiced intensive therapeutic lifestyle change (ITLC) even though most (57%) considered it an essential aspect of LM. There was agreement (94%) that LM is essential to mainstream medicine. Conclusion: Survey respondents, regardless of certification status, agreed that becoming an ABLM diplomate both meets their certifying needs and offers substantial benefits, with the caveat that ABMS recognition is an aspirational goal.*

Keywords: member survey; board certification; lifestyle medicine; American College of Lifestyle Medicine; American Board of Lifestyle Medicine; intensive therapeutic lifestyle change

Introduction

Certification of physicians in lifestyle medicine (LM) is a recent phenomenon, with the American Board of Lifestyle Medicine (ABLM), created in 2016, recognizing its first diplomates in 2017. The rationale for establishing ABLM as an independent board that could recognize physicians with specialized training and knowledge, arose from rapid growth of LM (Table 1) since the founding of the American College of Lifestyle Medicine (ACLM) in 2003. These trends, manifest with more than 2000

> "The ACLM and ABLM, despite their relatively recent appearance in medicine, are well-positioned to support the rapid and ongoing growth of LM by meeting the needs of members, clinicians, the public, educators, health systems, and other stakeholders."

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Table 1.

Growth of Interest in Lifestyle Medicine Using Diverse Metrics.

Metric	Description	Status and Growth Trends
ABLM	Physician diplomates, US and Canada	2009 certified physicians in 2022 vs 221 in 2017 year of first examinations, with 62% of diplomates in past 2 years
ACLM	Membership	8112 members in 2022 vs 12 when founded in 2003, with 91% joining in past 5 years
AJLM	Published manuscripts	550 publications in PubMed from inception in 2007 through May 2022, with 74% published in the past 5 years
Google trends	Lifestyle medicine as topic	Four-fold increase in lifestyle medicine as a worldwide search topic over past 5 years, as of May 2022
LMIG	ACLM-sponsored student interest groups, primarily at medical schools	80 sites (61 medical schools) in 2022, increased from 66 in 2021, 46 in 2020, 20 in 2019, 16 in 2018, and 10 or fewer sites in prior years, since inception in 2009
LMRC	Educational curriculum that can be integrated with medical residency programs	84 residency sites (over 120 programs) by Summer 2022, increased from 49 sites (82 programs) in 2021, 17 sites (29 programs) in 2020, 8 sites (13 programs) in 2019, and 4 sites (7 programs) in 2018 (inception year)
PubMed	"life style" as MeSH search term	70 976 publications as of May 2022, with 21% past 5 years, 45% past 10 years, and 66% past 15 years
PubMed	"lifestyle medicine" or "life style medicine" in any search field	788 publications as of May 2022, with 64% in past 5 years, 86% past 10 years, and 89% past 15 years

Abbreviations: ABLM, American Board of Lifestyle Medicine; ACLM, American College of Lifestyle Medicine; AJLM, American Journal of Lifestyle Medicine; LMIG, Lifestyle Medicine Interest Group; LMRC, Lifestyle Medicine Residency Curriculum; MeSH, medical subject hearing.

U.S. and Canadian diplomates (June 2022), prompt consideration of member attitudes regarding LM and certification, and how these attitudes might shape the future of LM as a young, dynamic, and rapidly growing medical specialty.

Certification of physicians in the U.S. began in 1917 with the American Board of Ophthalmology, leading to the American Board of Medical Specialties (ABMS) in 1937, which since 1991 includes 24 member boards. Boards arose in the early 20th century primarily to define the boundaries and content of specific specialties, as a voluntary system deemed a mark of excellence and professional achievement.[1]

Although still voluntary, board certification is increasingly recognized by consumers, health systems, and insurers as a highly desired, or even mandatory, credential. Most boards issued lifetime certificates until 2002, when all ABMS boards agreed upon standards for recertification and evaluation of practice performance every 6- to 10-years, through maintenance of certification (MOC).

The 3 leading entities in the U.S. that collectively oversee physician board certification in 26 recognized medical specialties (excluding LM) are the ABMS, with 950 000 certified diplomates by 24 member boards,[2] the American Osteopathic Association (AOS), with 38 000 certified diplomates by 18 medical specialty boards,[3] and the American Board of Physician Specialties (ABPS), with 5000 certified diplomates by 20 governing boards.[4] The ABLM is one of many U.S. independent specialty boards (not affiliated with ABMS, AOS, or ABPS), but does require physician diplomates be board-certified in their primary specialty by an ABMS member board or AOS as a prerequisite to further certification in LM.[5] Additional recognition, as an LM specialist/intensivist, can be achieved after completing a 1-year LM specialist/intensivist fellowship (educational pathway) or with a threshold level of clinical and

scholarly activity in LM (experiential pathway).

The need for this survey arose from a guiding principle upon which ABLM was founded, namely, that eventual ABMS recognition of lifestyle medicine as a subspecialty or member board was needed to fully establish lifestyle medicine as a legitimate specialty of mainstream medicine. This premise, however, had never been validated through feedback from current, and future, ABLM diplomates, so the need for a survey was apparent. In particular, the rapid growth of ABLM diplomates in recent years provide a robust potential survey base, and the growing interest in LM certification created an opportune time to incorporate diplomate feedback into future collaborative efforts.

Methods

A survey invitation was sent electronically to all physician members of ACLM with a completion incentive based on a random drawing from all respondents for 5 free registrations to the fall 2022 annual meeting of ACLM (approximately an $800 value). The 49-item survey was created in Microsoft Forms and completed using a web-based interface. Descriptive information was anonymous, and limited to essential information to reduce administrative burden, with data including ACLM membership year, country of residence, state (in U.S.) of clinical practice, gender, medical specialty, percentage of clinical practice time dedicated to lifestyle medicine, ABLM diplomate status, and intent to pursue certification if not a current ABLM diplomate.

In addition to basic, descriptive information, the broad survey topics were achieved through consensus of the ABLM Board of Directors, and included ABLM certification benefits, the general impact of certifying body in lifestyle medicine, the personal impact (on the diplomate) of certifying body in lifestyle medicine, the future of certification in lifestyle medicine, intensive therapeutic lifestyle change (ITLC), and the relationship of lifestyle medicine to mainstream medicine. A draft of the survey questions was provided to members of the ABLM Board of Directors for feedback and revision prior to agreeing upon the final survey format. The survey required approximately 15 minutes of time for completion.

Most responses were graded with a 5-point Likert scale of strongly agree, agree, neutral, disagree, and disagree strongly. For purposes of analysis and presentation, the strongly agree and agree responses were combined as "agree," with the strongly agree responses listed parenthetically in all summary tables. The same format was followed for strongly disagree and disagree responses. Descriptive and analytic statistical analysis was performed using IBM SPSS Statistics, version 28. Comparison of responses for ABLM diplomates vs those not certified by ABLM was performed with the independent-samples Mann–Whitney U test, with a 2-tailed significance value of $P = .05$.

Results

The survey response rate of 5.5% included 351 of the 6334 ACLM members in the eligible sample, but the survey sample (Table 2) was representative of the membership regarding gender, country of residence, and United States census region. The sample included a higher percentage of ABLM diplomates (63% vs 22%), so responses were categorized and compared in all subsequent tables for ABLM diplomates vs respondents who were not ABLM certified. For those who were not ABLM diplomates, 31% indicated they did plan to pursue eventual ABLM certification. Respondents were mostly in primary care specialties (69%) and spent a median 30% of their clinical practice in lifestyle medicine, with an interquartile range of 15% to 60%.

American Board of Lifestyle Medicine vs American Board of Medical Specialties as Certifying Body

There was agreement (Table 3) that ABLM certification is a source of personal pride (95%), could help in marketing clinical services (85%), would keep skills and knowledge current (88%), and would increase job opportunities (60%). Conversely, few agreed (13%) that certification could enhance salary or compensation. When asked about additional ABLM certification benefits, the most frequent responses (Table 4) were to (a) foster credibility, legitimacy, and recognition of expertise, and (b) to improve patient outcomes through trust, education, and coaching

Most agreed (Table 5) that either ABLM (54%) or ABMS (64%) could promote LM as part of mainstream medicine in the future, but existing ABLM diplomates were more likely to prefer ABMS (72 vs 51%, $P < .001$). Similarly, most agreed (77%) that recognition of LM as an ABMS member board was needed for legitimacy with other ABMS medical specialties, again with ABLM diplomates having higher agreement (80 vs 71%, $P < .001$). A minority of respondents (32%) felt that patients or consumers would care if certification was done by ABLM vs ABMS but most (71%) felt that insurers, health systems, and other purchasers would care about the certifying body.

Responses were evenly distributed (Table 6) as to whether certification by ABMS would better meet the

Table 2.

Descriptive Characteristics of Survey Respondents and Eligible Sample.

Characteristic	Survey Respondents (N = 351)	Eligible Sample (N = 6334)
ACLM membership year, mean (SD); range	2019 (2.85); 2004–2022	2020 (2.31); 2003–2022
Country of residence		
United States	88.3%	89.0%
Canada	5.4%	3.6%
Other	6.2%	7.4%
United States census region		
South	34.9%	35.1%
West	28.8%	32.0%
Midwest	19.9%	17.3%
Northeast	16.3%	15.6%
Female gender	68.4%	65.7%
Diplomate of ABLM	63.0%	22.4%
Percentage of clinical practice related to lifestyle medicine, median (IQR); range	30% (15%, 60%); 0–100%	—
Primary specialty		
Family medicine	37.0%	—
Internal medicine	21.7%	—
Pediatrics	6.0%	—
Obstetrics and gynecology	4.6%	—
Psychiatry or neurology	4.3%	—
Emergency medicine	4.0%	—
Physical medicine and rehabilitation	2.6%	—
Other specialty (all 1.5%)	19.8%	—

Abbreviations: ABLM, American Board of Lifestyle Medicine; ACLM, American College of Lifestyle Medicine.

needs of practitioners than certification by ABLM, with ABLM diplomates agreeing more often that ABMS was preferred (34% vs 22%, $P = .016$). Of note, the current process of ABMS certification in the clinician's primary specialty as prerequisite for ABLM certification in LM was strongly preferred (79%) over having ABMS offer primary certification in LM as a distinct specialty. Many respondents expressed concern (69%) that if certification was done by ABMS, it could limit professional opportunities for diplomates and that the current ABLM process would be better (77%) than having primary certification through ABMS.

Future of Lifestyle Medicine and Intensive Therapeutic Lifestyle Change

Responses were split (Table 7) between whether LM can grow best under ABLM (51%) vs ABMS (42%), but most (65%) supported eventual ABMS recognition with only a minority (32%) considering it a priority. Even fewer respondents

Table 3.

Perceived Benefits of Certification in Lifestyle Medicine.

Instructions: Please rate your level of agreement, or disagreement, with the following statements about the potential BENEFITS of certification in lifestyle medicine. If you are not currently certified in lifestyle medicine, then respond to the questions based on how future certification might provide you with the suggested benefit						
	Likert category, %			Agree, % (Response, mean)[a]		
Statement (Respondents, N = 351)	Agree (strongly)	Neutral	Disagree (strongly)	Not ABLM certified[b,c]	ABLM diplomate	*P*-Value[c]
Certification in LM by the ABLM is (or would be) a **source of personal pride** (n = 350)	95 (64)	4	<1 (<1)	90 (1.58)	98 (1.31)	<.001
Certification in LM by the ABLM can help (or would help) **market my clinical services** (n = 348)	85 (39)	11	3 (<1)	82 (1.88)	87 (1.76)	.168
Certification in LM by the ABLM increases (or would increase) my **job opportunities** (n = 342)	60 (19)	31	9 (2)	54 (2.45)	64 (2.22)	.023
Certification in LM by the ABLM increases (or would increase) my job **salary or compensation** (n = 327)	13 (6)	43	44 (8)	9 (3.36)	15 (3.30)	.987
Certification in LM by the ABLM, plus MOC, keeps (or would keep) my **knowledge and skills current** (n = 344)	88 (40)	9	3 (2)	87 (1.82)	89 (1.73)	.428
Certification in LM by the ABLM is (or would be) sufficient **to meet my certification needs** (n = 327)	67 (25)	18	15 (6)	62 (2.37)	70 (2.23)	.111

Abbreviations: ABLM, American Board of Lifestyle Medicine; LM, lifestyle medicine; MOC, maintenance of certification.
[a]Agree percentage includes "agree" and "strongly agree" responses; mean is from 1 (agree strongly) to 5 (disagree strongly).
[b]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[c]Independent-samples Mann–Whitney U test.

(19%) would support transitioning to ABMS as the certifying body for LM without a legacy, or preapproval, pathway for existing ABLM diplomates. Few respondents were in favor of a LM residency (15%) or fellowship (24%) for ABMS certification.

Whereas only 22% of respondents reported practicing ITLC, most (57%) considered it a core competency, ideally (52%) with additional training (Table 8). A minority (27%) was interested in formal ITLC training or pursing subspecialty recognition (25%), and they were generally not in favor (40%) of offering subspecialty certification in ITLC or considering this of value to the public. There was very strong agreement that primary care physicians (97%) and specialty physicians (93%) receive training in the principles and practice of LM (Table 9), but much less agreement regarding training in ITLC (47% for primary care physicians vs 28% for specialists). Few respondents (17% agree, 4% strongly agree) were concerned that anything less than ITLC runs the risk of making LM, in general, appear less effective than it really is in managing chronic disease.

Discussion

Our survey offers the first, systematic insights into how ACLM members perceive board certification, with some key insights summarized in Table 10. Certification is a source of personal pride and accomplishment for diplomates, with 67% agreeing that ABLM as the certifying body meets their needs. Both ABLM and ABMS could promote LM as part of mainstream medicine, with little concern that patients would care about which entity offered the certification. Whereas almost half expressed interest in having ABMS as the future certifying body, this is an aspirational goal with no immediate urgency. Moreover, 77% agreed that the current process of ABLM certification, which requires all diplomates to first be certified in an existing ABMS specialty, offered value and professional benefits beyond what they could get if certification was handled by only the ABMS. Further, almost half felt that having ABMS as the certifying body could negatively impact the quality of education, by reducing the relevance of ABLM.

Strengths of our research include face validity based on extensive

Table 4.

Open Text Response for Additional ABLM Certification Benefits.

Idea	Number	Percent
1. Foster credibility, legitimacy, and recognition of expertise	54	24.4
2. Improve patient outcomes through trust, education, and coaching	32	14.5
3. Enhance and solidify knowledge, ability, skills	22	10.0
4. Achieve personal growth, satisfaction, and self-confidence	21	9.5
5. Create networking opportunities within lifestyle medicine community	19	8.6
6. Increase employment opportunities	15	6.8
7. Facilitate and lifestyle medicine training and initiatives	14	6.3
8. Promote personal health and be a role model for others	13	5.9
9. Enhance and market clinical practice	9	4.1
10. Enable community service and outreach	8	3.6
11. Address root causes of chronic disease	7	3.2
12. Access to educational resources and research	4	1.8
13. Enhance communication among healthcare providers	3	1.4

Abbreviations: ABLM, American Board of Lifestyle Medicine.

feedback on question stems and responses from the ABLM board of directors, which helped promote clarity, relevance, and timeliness. We used a 5-point Likert response scale with well-defined cut-points that are standard in survey research. The sample of 351 respondents, although reflecting only 5.5% of ACLM physician members, is representative of the accessible sample (Table 2), except for a higher prevalence of ABLM diplomates (63% vs 22%), which may improve insight into the certification value and process. About 65% of respondents practice primary care (Table 2), potentially limiting generalizability to specialty settings. Last, it is unclear how well respondent perceptions about the public, insurers, and health systems truly reflect their views on the value and meaning of certification in LM.

History and Value of Board Certification

Board certification is a natural consequence of medical specialization, which began with specific body parts in ancient Greece and continued later in Rome under the humoral theory of systemic disease.[6] Medical specialists, however, first became a recognizable social category in 19th century Europe and North America, leading to a community of scholars who considered proper classification the best way to manage population health and promote innovation. Specialist recognition through board certification began in the early 20th century, which defined specialty boundaries and offered a voluntary system to acknowledge physician excellence and achievement.[1] Although board certification remains largely voluntary, it is increasingly sought by consumers, insurers, and health systems as a highly desired, or sometimes mandatory, credential.

The value of board certification is summarized nicely by the ABMS, which states "Certification by an ABMS Member Board helps demonstrate to the public that a physician and medical specialist meets nationally recognized standards for education, knowledge, experience, and skills and maintains their certification through continuous learning and practice improvement in order to provide high quality care in a specific medical specialty or subspecialty."[7] Similarly, the ABPS notes that "Board certification with the ABPS serves as demonstrable proof that a physician has the skills and knowledge to deliver world-class medical care."[8] With regards to LM, the ABLM mission statement

Table 5.

General impact of certifying body for lifestyle medicine.

Instructions: In considering the following statements, please keep in mind that the ABLM, established in 2015 as one of approximately 200 independent, medical certifying bodies in the United States, has certified (through 2021) about 1800 US physicians and over 1200 physicians in 72 countries. In contrast, the ABMS, established in 1933, provides board certification in the US for 24 member boards, the last of which, medical Genetics, was added in 1991						
Statement (Respondents, N = 351)	**Likert category, %**			**Agree, % (Response, mean)[a]**		
	Agree (strongly)	**Neutral**	**Disagree (strongly)**	**Not ABLM certified[b]**	**ABLM diplomate**	***P*-Value[c]**
Certification of physicians in LM by the **ABLM is sufficient to promote LM as** part of mainstream medicine (n = 344)	54 (15)	19	28 (3)	55 (2.60)	53 (2.64)	.695
Certification of physicians in LM in the future by **ABMS, instead of ABLM, is needed to promote LM** as part of mainstream medicine (n = 333)	64 (27)	22	14 (2)	51 (2.51)	72 (2.09)	<.001
Recognition of **LM as an ABMS member board** (e.g., a distinct medical specialty) is necessary for LM to be recognized by mainstream medicine as valid and important, at the same level as other ABMS medical specialties (n = 341)	77 (33)	14	9 (2)	71 (2.23)	80 (1.89)	<.001
Patients and other consumers of LM will care significantly as to whether a physician is certified in LM by the ABLM or by the ABMS (n = 344)	32 (11)	23	45 (11)	29 (3.19)	34 (3.08)	.357
Insurers, health systems, and other purchasers of LM will care significantly as to whether a physician is certified in LM by the ABLM or by the ABMS (n = 322)	71 (29)	19	11 (3)	65 (2.28)	74 (2.05)	.038
Insurers, health systems, and other purchasers of LM will significantly **increase reimbursement for LM services** if a physician is certified in LM by the ABMS instead by the ABLM (n = 307)	52 (16)	29	20 (5)	42 (2.69)	57 (2.48)	.029

Abbreviations: ABLM, American Board of Lifestyle Medicine; ABMS, American Board of Medical Specialties; LM, lifestyle medicine.
[a]Agree percentage includes "agree" and "strongly agree" responses; mean is from 1 (agree strongly) to 5 (disagree strongly).
[b]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[c]Independent-samples Mann–Whitney U test.

reads, "Certification as an ABLM diplomate signifies specialized knowledge in the practice of LM and distinguishes a physician as having achieved competency in LM."[9] The common thread in all of these statements is assuring patients, consumers, and other stakeholders that the practitioner has demonstrated the skill, abilities, and knowledge to deliver medical care of the highest quality.

Perceptions of higher quality of care from board-certified physicians are supported by studies associating better outcomes with certification, but effect sizes are modest and based on observational studies that do not necessarily imply causation.[10] More recently, however, a historical cohort of over 350 000 patients followed for 7 years found lower mortality and length of stay for attending physicians trained in a residency program with a 80% or greater certification rate when managing patients with heart failure, heart attacks, pneumonia, or gastrointestinal hemorrhage.[11] Other implications of certification, which overlap with those in Tables 3 and 4, include hospital staff privileges, peer recognition in professional societies, potential higher compensation, a competitive advantage (over non-certified physicians) in attracting patients, and establishing a standard for care and expert testimony in medical malpractice actions.[12] Whereas all respondents considered certification by ABLM a source of personal pride (Table 3), agreement was significantly higher, and nearly universal, for diplomates compared to non-diplomates (98% vs 90%, $P < .001$).

Table 6.

Personal impact of certifying body for lifestyle medicine.

Instructions: Please rate your level of agreement, or disagreement, with the following statements about the potential IMPACT of the CERTIFYING BODY for LM on YOU as a clinician. In considering the following statements, please keep in mind that if certification in LM is done by the ABMS, instead of by ABLM, there are two ways this could be achieved						
1. The first pathway to ABMS certification—primary certification—would be to have LM recognized as an independent member board and distinct medical specialty, with the same status as the other 24 member boards (e.g., preventive medicine, family medicine, surgery). This process would likely take 10 or more years and would first require a robust base of ACGME (Accreditation College for Graduate Medical Education) approved residency training programs in LM with a standard curriculum and competencies						
2. The second pathway to ABMS certification—subspecialty certification—would be to have LM recognized as a subspecialty under one or more existing ABMS member boards (e.g., sleep medicine is a subspecialty of anesthesiology, family medicine, internal medicine, otolaryngology, pediatrics, and neurology). This would allow board-certified diplomates in the primary board to get sub-certification in LM, based on experience, training, or potentially completing a fellowship. This process could be accomplished faster than the pathway above (e.g., LM as a distinct specialty), but could limit certification in LM to only those specialties offering sub-certification						
	Likert category, %			Agree, % (Response, mean)[a]		
Statement (Respondents, N = 351)	Agree (strongly)	Neutral	Disagree (strongly)	Not ABLM certified[b]	ABLM diplomate	*P*-Value[c]
Certification of physicians in LM by **ABMS would better meet my certification needs** than does the current process of ABLM certification (n = 329)	29 (9)	37	34 (9)	22 (3.23)	34 (2.93)	.016
If certification in LM was accomplished through ABMS, **the best mechanism would be *primary certification*** as a distinct, medical specialty (n = 331)	23 (9)	24	53 (13)	21 (3.47)	25 (3.27)	.086
If certification in LM was accomplished through ABMS, **the best mechanism would be *subspecialty certification*** as a subspecialty under another medical specialty (n = 333)	71 (28)	16	14 (3)	69 (2.26)	73 (2.14)	.409
Primary certification of physicians by ABMS in LM as a distinct specialty **could limit professional opportunities for diplomates** because they may not be certified by another medical specialty (e.g., internal medicine, family practice, preventive medicine) or eligible for a fellowship in another medicalspecialty (n = 336)	69 (24)	20	12 (2)	71 (2.17)	68 (2.22)	.660
The current process of ABLM certification in LM, which requires all diplomates to first be certified in an existing ABMS specialty, **provides me (or would provide me) with professional benefits and value** beyond what I would get if only certified in LM as a distinct, ABMS specialty (n = 333)	77 (29)	15	8 (3)	79 (2.09)	76 (2.02)	.751
If LM was certified by ABMS, under either of the 2 pathways described, the **quality of education could be negatively impacted** by reducing the relevance of ABLM (as it currently exists), by directing fees (from diplomates) to ABMS, and by potentially directing member dues away from ACLM to a primary ABMS specialty (n = 306)	46 (12)	40	14 (4)	50 (2.57)	45 (2.60)	.735

Abbreviations: ABLM, American Board of Lifestyle Medicine; ABMS, American Board of Medical Specialties; LM, lifestyle medicine.
[a]Agree percentage includes "agree" and "strongly agree" responses; mean is from 1 (agree strongly) to 5 (disagree strongly).
[b]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[c]Independent-samples Mann–Whitney U test.

Table 7.

Future of Certification in Lifestyle Medicine.

Instructions: Please rate your level of agreement, or disagreement, with the following statements about the potential FUTURE of CERTIFICATION for lifestyle medicine						
Statement (Respondents, N = 351)	Likert category, %			Agree, % (Response, mean)[a]		
	Agree (strongly)	Neutral	Disagree (strongly)	Not ABLM certified[b]	ABLM diplomate	*P*-Value[c]
LM can best grow and **thrive as a specialty if certification is done by ABLM** (n = 327)	51 (17)	37	12 (1)	53 (2.44)	51 (2.44)	.939
LM can best grow and **thrive as a specialty if certification is done by ABMS** (n = 321)	42 (13)	37	21 (5)	35 (2.87)	46 (2.60)	.023
LM should **eventually become a member board** (specialty) of ABMS (n = 334)	65 (19)	24	11 (9)	57 (2.46)	70 (2.19)	.005
I would still support transitioning to ABMS as the certifying body for LM even if existing **diplomates of ABLM *could NOT* be legacied** in (preapproved) as board-certified (n = 340)	19 (4)	14	67 (32)	22 (3.62)	18 (3.83)	.060
LM should become a member board (specialty) **of ABMS as rapidly as possible** (n = 329)	32 (12)	38	30 (9)	24 (3.16)	36 (2.84)	.007
LM as a member board (specialty) of **ABMS is an aspirational goal**, but there is no rush to achieve it (n = 329)	48 (5)	29	23 (5)	55 (2.68)	45 (2.78)	.232
Completing **a residency in LM** at the specialist/intensivist level should be required for ABMS board certification (n = 337)	15 (3)	22	63 (20)	13 (3.79)	16 (3.58)	.024
Completing a **fellowship in LM** at the specialist/intensivist level should be required for ABMS board certification (n = 342)	24 (4)	27	49 (16)	22 (3.54)	26 (3.26)	.013

Abbreviations: ABLM, American Board of Lifestyle Medicine; ABMS, American Board of Medical Specialties; LM, lifestyle medicine.
[a]Agree percentage includes "agree" and "strongly agree" responses; mean is from 1 (agree strongly) to 5 (disagree strongly).
[b]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[c]Independent-samples Mann–Whitney U test.

Implications of the Board Certifying Body

When certification is done by an independent medical board, not associated with ABMS, concerns can arise regarding legitimacy and equivalency of the certifying process.[13] This is much less of a concern when the independent board deals with a specialty that does not significantly overlap with specialty certification offered by ABMS, which is the case for LM because it is relevant to nearly all medical specialties. Given this diversity, the ABLM first requires a potential diplomate to be board-certified by ABMS in their primary specialty, with certification by ABLM as an add-on when qualifying criteria (experiential or educational) are satisfied and an examination is successfully completed. Moreover, 77% of survey respondents (Table 6) agreed that this dual process—with board certification by ABMS as a prerequisite to ABLM recognition as a LM diplomate—provides, or would provide (if not yet ABLM certified), professional benefits and value beyond what they could get if only certified by ABMS in LM as a distinct specialty.

The current model of ABLM physician certification as an add-on to the primary ABMS board serves diplomates well (Tables 3–6), despite 65% agreeing (Table 7) that LM should eventually become an ABMS member board (but with no urgency). Moreover, 77% agree (Table 5) that eventual ABMS recognition is needed for LM to be fully recognized by mainstream medicine as comparable to other official ABMS specialties. As LM is more formally integrated into

Table 8.

Intensive Therapeutic Lifestyle Change.

Instructions: We would appreciate your opinion regarding intensive therapeutic lifestyle change (ITLC), which involves intensive support (often group-based), facilitated by a physician trained and certified in lifestyle medicine, with specific measures of engagement, adherence, and health outcomes. ITLC is generally considered the best way to treat advanced or severe chronic disease, or to achieve disease reversal or remission. In contrast, less intense therapeutic lifestyle interventions are usually sufficient for primary prevention of chronic disease or to achieve risk reduction							
	Response, %				**Yes, %**		
Statement (Respondents, N = 351)	**Yes**	**No**	**Maybe**	**Unsure, no opinion**	**Not ABLM certified[a]**	**ABLM diplomate**	***P*-Value[b]**
I **practice ITLC** or I am involved in a team that practices ITLC (n = 315)	22	71	5	2	15	26	.040
All physicians trained in lifestyle medicine should be able to do ITLC (n = 351)	57	12	24	7	55	58	.709
Physicians who do **ITLC should ideally have additional training** beyond the basic lifestyle medicine curriculum (n = 351)	52	16	22	10	49	54	.509
Physicians who do **ITLC should ideally have specialized residency or fellowship training** in the knowledge, skills, and abilities to optimally perform ITLC (n = 351)	26	29	31	15	22	29	.026
I would **personally be interested in formal training, such as a fellowship program**, to achieve optimal competency in lifestyle medicine (n = 351)	27	37	27	9	24	29	.068
Beyond board certification in lifestyle medicine, it would be **beneficial to offer additional subspecialty certification** as an intensivist who is fellowship-trained in advanced lifestyle medicine strategies and competencies (n = 351)	40	16	30	15	35	42	.118
If there was a pathway for subspecialty certification as a lifestyle medicine intensivist **I would personally be interested in pursuing** that recognition	25	32	31	11	24	26	.159
Patients and the public would benefit by knowing that a lifestyle medicine provider had subspecialty certification as a lifestyle medicine intensivist (beyond the current level of specialty certification), with additional competency in ITLC (n = 351)	40	18	25	18	40	39	.988

Abbreviations: ABLM, American Board of Lifestyle Medicine; ITLC, intensive therapeutic lifestyle change.
[a]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[b]Pearson chi-square.

Table 9.

Lifestyle Medicine and Mainstream Medicine.

Instructions: Please rate your level of agreement, or disagreement, with the following questions about lifestyle medicine practice as it relates to mainstream medicine, overall						
	Likert category, %			Agree, % (Response, mean)[a]		
Statement (Respondents, N = 351)	Agree (strongly)	Neutral	Disagree (strongly)	Not ABLM certified[b]	ABLM diplomate	*P*-Value[c]
All **primary care physicians should be trained** in the principles and practice of lifestyle medicine (n = 351)	97 (75)	2	<1	98 (1.28)	96 (1.29)	.742
All physicians, regardless of specialty, should be trained in principles and practice of lifestyle medicine (e.g., as part of the ACGME common program requirements) (n = 350)	93 (60)	4	3 (<1)	91 (1.50)	93 (1.51)	.882
All **primary care physicians should be trained** in ITLC (n = 340)	47 (22)	28	25 (4)	52 (2.41)	45 (2.71)	.021
All physicians, regardless of specialty, should be trained in ITLC (n = 339)	28 (12)	30	43 (10)	33 (2.89)	25 (3.26)	.002
Anything less than ITLC (e.g., fellowship training) runs the risk of making lifestyle medicine, in general, appear less effective than it really is in managing chronic disease (n = 339)	21 (4)	27	52 (9)	16 (3.42)	24 (3.32)	.499
Any use and implementation of lifestyle medicine by physicians, even if not meeting the standards for ITLC, is still beneficial and should be encouraged (n = 350)	94 (51)	5	<1	96 (1.53)	93 (1.57)	.678

Abbreviations: ABLM, American Board of Lifestyle Medicine; ITLC, intensive therapeutic lifestyle change.
[a]Agree percentage includes "agree" and "strongly agree" responses; mean is from 1 (agree strongly) to 5 (disagree strongly).
[b]37% of respondents identified as not certified by ABLM; 63% identified as diplomates of ABLM.
[c]Independent-samples Mann–Whitney U test.

residency programs (especially primary care) and specialized fellowship programs expand, the number of physicians who practice primarily LM, including ITLC, will likely grow significantly.[5] These clinicians with more intense LM training and experience can be recognized as specialist/intensivist diplomates by ABLM, but in the future may be more suited to direct ABMS recognition as a subspecialty or member board. For those with less intense training, who seek certification as physician diplomates through ABLM, the existing add-on process to a primary ABMS board is likely to persist.

There were significant differences (Tables 5 and 6) regarding implications of the certifying body for LM and for ABLM diplomates vs non-diplomates. Diplomates were more likely to agree that ABMS certification offered advantages over ABLM certification for recognition as part of mainstream medicine (72% vs 51%, $P < .001$), gaining equivalency to other ABMS medical specialties (80% vs 71%, $P < .001$), getting enhanced compensation from purchasers of health care (57% vs 42%, $P = .029$), and having their future certification needs met (34% vs 22%, $P = .016$). Conversely, there were no differences in whether consumers would care about the certifying body, or if ABMS certification would best be achieved by subspecialty certification under another member board or directly as a distinct, new member board.

Future of Board Certification in Lifestyle Medicine

The future of certification in LM will likely continue to include maintenance of certification (MOC), regardless of certifying body. Certification was initially a lifetime credential until the 1960s when time-limited certificates were introduced that required periodic

Table 10.

Key Insights from ACLM Member Physicians Regarding Certification in Lifestyle Medicine.

Topic	Insight or Perception	Impact of ABLM certification
ABLM certification benefits	ABLM certification is a source of personal pride that could help market clinical services and increase job opportunities, but is unlikely to increase compensation	Diplomates more likely to note personal pride and job opportunities
Certifying body	ABLM and ABMS can meet certification needs and promote lifestyle medicine as part of mainstream medicine, with little concern by patients regarding the certifying body but a preference by payers for ABMS	Diplomates favor ABMS for recognition in mainstream medicine and by payers
ABMS role	ABMS certification in lifestyle medicine is an aspirational goal, with no immediate urgency, and would best be achieved through subspecialty certification, not through membership as a primary board	No impact on responses
Role of residency or fellowship	ABMS certification in lifestyle medicine at the specialist/intensivist level should not require a residency or fellowship in lifestyle medicine	Diplomates more likely to favor residency or fellowship training
ITLC	ITLC is an essential component of lifestyle medicine that all physicians should be able to implement with little interest, or perceived need for, fellowship training or additional subspecialty certification	Diplomates more likely to be practicing ITLC and to see value in specialized training
Mainstream medicine	All physicians should be trained in lifestyle medicine as part of the ACGME common program requirements, even if they are unable to meet the standards for ITLC	Diplomates favor training all clinicians in ITLC

Abbreviations: ABLM, American Board of Lifestyle Medicine; ABMS, American Board of Medical Specialties, ACLM, American College of Lifestyle Medicine; ITLC, intensive therapeutic lifestyle change.

reexamination. Recertification was superseded by continuing certification (MOC) in 2000, emphasizing physician learning, advancement, and current competence.[14] The ABMS requires all member boards to offer MOC, with the intent of "…serving diplomates, the public and the profession by providing a system that supports the ongoing commitment of diplomates to provide safe, high quality, patient-centered care."[14] ABLM currently offers MOC to diplomates, but the process will likely evolve concurrent with other changes in LM medicine training and certification. Similar to the ABMS, the AOA uses osteopathic continuous certification[15] but, in contrast, the ABPS offers recertification every 8 years for diplomates of ABPS or other boards (ABMS, AOA) whose diplomates prefer this process over MOC.[16]

Regarding the future of board certification in LM, current ABLM diplomates again showed a preference for more ABMS engagement than did non-diplomates (Table 7). Diplomates were more likely to agree that LM would grow best if certification was done by ABMS (46% vs 35%, $P = .023$), that LM should ultimately become an ABMS member board (70% vs 57%, $P = .005$), and that ABMS certification should require completing a residency in LM (16% vs 13%, $P = .024$) or a fellowship program (26% vs 22%, $P = .013$). Diplomates and non-diplomates agreed on ABMS recognition as a non-urgent, aspirational goal, ideally with a legacy exception to ensure that existing ABLM diplomates get preapproved for certification should ABMS become the certifying body.

Conclusion

LM is a vibrant, rapidly growing, and increasingly relevant medical

discipline (Table 1) whose diplomates are well-served by the existing model of ABMS certification. The future is likely to see changes, and evolution, of the MOC process and the relationship of LM to ABMS, as a potential member board, subspecialty board, or focused practice designation[17] (not discussed in the survey). Concurrent with the evolution of certification, LM training will evolve through enhanced integration with residency training, expansion of fellowship opportunities, and potential inclusion in residency common program requirements.

The ACLM and ABLM, despite their relatively recent appearance in medicine, are well-positioned to support the rapid and ongoing growth of LM (Table 1) by meeting the needs of members, clinicians, the public, educators, health systems, and other stakeholders. Survey respondents, regardless of certification status, agreed that becoming an ABLM diplomate both meets their certifying needs and offers substantial personal and professional benefits, with the caveat that ABMS recognition is an aspirational goal. The ABLM is committed to maximizing the value of certification, through ongoing stakeholder feedback and by engaging leadership at ABMS and its member boards on the value, relevance, and importance of LM as an essential aspect of mainstream medical practice.

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