here’s how we’re doing it...
Everywhere in health care, people are **REDESIGNING** their blueprint for the future. **here’s how we’re doing it….**
This year, government and business exerted tremendous pressure on the health care industry to contain costs, which left physicians questioning how to position themselves to function effectively in a more integrated, cost-conscious system.

Amid that urgency and uncertainty, the MMS was present at virtually every debate about how to redesign health care, advocating for physicians and their patients at every twist and turn.

Ably led by our president, Alice A. Tolbert Coombs, MD, Society physicians spoke at scores of hospital, specialty society, and community meetings across the Commonwealth. We educated physicians and the public about proposed policies, articulated the Society's stance on contentious issues, and listened to physician concerns and assessed their readiness for change.

We spoke out about Medicare physician payments and offered testimony at the State House on 100 pieces of legislation that could affect our patients' well-being. We developed CME programs to help physicians better understand accountable care organizations and how to achieve meaningful use of electronic health records.

We helped patients make good decisions about their health, and our Publishing Division continued to make its world-class content more relevant and accessible in the daily practice of medicine.

Meanwhile, a special MMS task force of physicians and policy experts developed a set of 18 comprehensive health-reform principles that the House of Delegates unanimously adopted in May — they will form the bedrock of this year's advocacy.

Thanks to you, the Society's leaders and all its members, physicians will continue leading the redesign of health care so that patients come first and what they care about is preserved.

— Corinne Broderick, Executive Vice President
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FEDERAL ADVOCACY

POLITICIANS REPLAY GRIDLOCK IN WASHINGTON...

...WHILE THE MMS CONTINUES TO FIGHT FOR PATIENTS AND PHYSICIANS

The first 12 months after the passage of the federal Accountable Care Act (ACA) helped shape the Massachusetts health care system from a distance. Three big trends drove the Medical Society’s advocacy on Capitol Hill.

ACA UNCERTAINTY

The federal reform law contained more than a thousand clauses that began, “The secretary [of human services] shall...” During the summer of 2010, Washington’s regulatory machinery revved up, adding some details to the ACA’s proclamations.

But the Republican sweep of the U.S. House in November 2010 made the ACA vulnerable overnight. With a presidential veto certain, the GOP couldn’t repeal the law outright, but Republicans set out to withhold funding for certain aspects of the law, while others challenged the ACA in court. Of direct concern to Massachusetts was the fear that Washington’s generous Medicaid waivers would be cut, compromising the state’s 2006 expansion of insurance coverage to more than 97 percent of residents.

The Medical Society also provided key testimony in September 2010 when the Institute of Medicine (IOM) held hearings on whether to eliminate the upward adjustment in Medicare fees for physicians in high-cost regions like Massachusetts. MMS President Alice T. Coombs, MD, told the panel, “Failure to recognize the basic costs of doing business will further erode physicians’ ability to practice medicine.” Several months later, an IOM report agreed that geographic payment adjustments were valid, but held open the possibility of recommending tweaks to the formula by which adjustments are calculated.

SGR UNRESOLVED

While the Medical Society worked diligently to persuade Congress to support a long-term fix to the flawed Medicare physician payment formula, our fiscal year concluded without any resolution to this longstanding problem. In late 2010, Congress postponed a 30 percent fee cut mandated by the formula until January 2012, hoping that a solution would arise. Soon after, the AMA invited the MMS to serve on two select advisory groups to develop alternatives to the SGR, in hopes of developing a fair and sustainable payment model for Medicare and Medicaid.
EHRS AND MEANINGFUL USE
The federal program supporting the implementation of electronic health records in physician offices was part of the stimulus legislation passed early in 2009. The entity coordinating EHR-adoption efforts in Massachusetts registered 2,500 physicians in its program before any other similar entity in any other state.

THUMBS DOWN ON PROPOSED MEDICARE ACO REGULATIONS
The MMS joined an eclectic chorus in criticizing the proposed regulations for Medicare ACOs that the Centers for Medicare and Medicaid Services released in March 2011. Our written comments cited the 65 quality measures as being too burdensome, the shared-savings model as being unrealistic, and the antitrust regulations as too restrictive. Echoing a reform principle passed by the MMS House of Delegates in May 2011, we said, “Physicians must be at the center of the decision-making in these systems. Payers and others whose primary responsibility is the financing of care should not govern clinical decisions or care models.”

Nationwide, the medical community was nearly unanimous in declaring the regulations impractical. Even some large integrated physician groups in Massachusetts, such as Atrius Health, said they had no plans to join such a program. Federal regulators began working on a rewrite almost immediately after the comment period closed.

Dr. Coombs and other MMS leaders meet Rep. Michael Capuano in Washington.
Readjusting to Market Forces in Massachusetts Health Care...

While Reform Legislation Percolates

Two years after a state commission recommended a migration to global payments for health care, fee for service remains the dominant payment system in the Commonwealth. Meanwhile, three major forces prompted the Society to marshal its resources to help physicians address significant changes.

Rising Health Care Costs

The twin impacts of the lingering economic slide and sustained health-insurance premium increases prompted government and business to exert unprecedented pressure on the health care industry to contain costs.

Health plans introduced new products that reward consumers with lower premiums if they accept limited choices of hospitals and other providers. These are becoming more popular among employers and individuals.

In the meantime, Blue Cross Blue Shield of Massachusetts has signed 14 provider groups — caring for a total of half a million patients — to its Alternative Quality Contract (AQC). The AQC bundles a fixed annual budget with significant bonuses for providers who meet rigorous cost and quality benchmarks.

Though most small physician groups have not signed the AQC, proponents cite the modest cost savings for the initial adopters as proof that global payment is feasible. However, Attorney General Martha Coakley issued a report in June 2011 casting doubt on whether global payments by themselves save money, saying the method could lock in or even worsen price differentials among providers.

Payment Reform Legislation

Governor Patrick fulfilled a reelection promise when he unveiled comprehensive payment reform legislation in February at a downtown breakfast meeting of the Greater Boston Chamber of Commerce. "If anyone is going to crack the code of cost containment, it will be we here in Massachusetts," the governor said at that time.

But the bill didn’t advance in the Legislature as quickly as the governor had hoped. Still, its introduction gave legislators and stakeholders a tangible document to debate, amend, and refine. Action is anticipated this fall and early next year.

Hospital Mergers

In an echo of the consolidation wave of the 1990s, hospitals merged this past year at a dizzying pace. The catalyst was the acquisition of the Caritas Christi Health System by a for-profit private equity firm. The new entity, renamed Steward Health Care, then took steps to buy hospitals in seven other communities in Massachusetts and Rhode Island. In quick succession, other hospitals, including Lahey Clinic and Beth Israel Deaconess Medical Center, began their own merger talks. Even two large health plans, Harvard Pilgrim and Tufts, considered a merger but then abandoned the idea. Finally, in June 2011, two physician-centered organizations, Atrius and Fallon Clinic, finalized their merger deal.
Massachusetts physicians were faced with a health care market that was changing fast, even before a single line of legislation had passed. But the MMS was there to advocate, educate, and support them at every turn.

**ADVOCACY**

The good news about the governor’s payment reform bill is that many of the Society’s key recommendations were included:

- Physician participation should not be mandatory.
- One size doesn’t fit all, and the state should encourage multiple payment-reform experiments.
- The bill promotes liability reform with apology protections and other measures to curb defensive medicine.

When the governor introduced his bill, MMS President Alice A. Tolbert Coombs, MD, told the news media, “We have long held that the practice of defensive medicine contributes to the cost of care. If these provisions are enacted, that will change behavior in and of itself.”

A key reason for the Society’s advocacy success was its deep involvement in more than a dozen committees, commissions, task forces, and working groups, both inside and outside state government. This unprecedented interaction with decision makers reflected both lawmakers’ interest in engaging key stakeholders in the ongoing dialogue and validation of the value Beacon Hill places on the Society’s guidance and counsel.

At the same time, the Society’s physician leaders spoke at more than 40 hospital, specialty society, and community meetings throughout the year. During these events we educated physicians and the public about the policy options on the table, disseminated the Society’s stance on contentious issues, gathered information about physician concerns, and assessed the uncertainty and readiness of the health care community to change. These meetings further strengthened the Society’s advocacy position.

In the meantime, a special MMS health reform task force, comprised of physicians and health policy experts, spent the year analyzing cost containment and delivery reform options and delivered a set of 18 comprehensive principles that the House of Delegates adopted unanimously. These principles have already been efficacious in guiding the Society’s advocacy on Beacon Hill and Capitol Hill as FY 2012 got underway.

**EDUCATION**

The Society hosted a number in-depth education programs and webinars on payment and delivery reforms, providing physicians with tools to start assessing their options (for more details, see page 14).

In addition, several new white papers and resources were posted on the MMS website, including a notable health care reform “how-to” guide from the American Medical Association.

**SUPPORT**

The MMS Physician Practice Resource Center (PPRC) continued its direct consulting work with physicians and has helped a number of practices evaluate their options and prepare for the new health care environment.

This coming year, we will add a new Accountable Care Solution Center (ACSC) to the MMS, providing a one-stop shop of practical resources and guidance for physicians in practices big and small.

Dr. Coombs speaks at the Doctors’ Day rally at the State House.
REFOCUSED PUBLISHING EFFORTS TO SUSTAIN CONTINUED GROWTH...

...ALIGN CONTENT AND SERVICES TO BETTER SERVE CUSTOMERS

In 2012, we will celebrate the *New England Journal of Medicine*’s 200th anniversary and the 25th anniversary of Journal Watch. We have done a great deal in the past few years to bring these publications into the electronic age. We’ve created new services and distribution channels, such as digital interactive CME cases and mobile applications, to serve the changing needs of our customers.

Moving forward, publishing looks to carefully broaden our scope of operations to expand our influence and drive our business beyond a single medical journal or a series of newsletters. We plan to package and deliver new value while building on the strength of the *New England Journal of Medicine* brand and our current product portfolio.

With unparalleled brand strength, superior content, strong business performance, a track record of digital innovation, and a deep understanding of our customers and audience, we’re in a strong position to move in that direction. We need to recognize that clinicians have great awareness of and respect for the *New England Journal of Medicine*, but also that changes in technology and practice and new forms of information are making original research and the journals that publish it less directly relevant to the daily practice of medicine. While advances in clinical science will continue to change practice and improve care, clinicians now synthesize new evidence through a broad and diverse set of secondary sources. Our goal is to develop new services to meet those changing needs.

POSITIVE RESULTS

In fiscal 2011, publishing took a conservative position on revenues due to continued economic uncertainties. Fortunately, we experienced a revenue rebound in almost all major channels. Revenues from pharmaceutical-based and online advertising were strong, and permissions revenues continued to grow. In addition, the library community responded positively to the launch of the NEJM Archive, which in three months generated more than half the number of sales projected for the entire year. Nevertheless, we continued to see an industry-wide decline in print subscriptions, as individuals continued to move toward institutional or online-only subscriptions.

Following a comprehensive brand and market exploration that yielded a clearer understanding of our audience’s diversity, we developed a three-pillared foundation for current and future publishing initiatives:

- Deepening our worldwide leadership as the premier publisher of medical research
- Engaging with our current clinician audience by increasing relevance and accessibility
- Extending connections to “needs-driven” practicing clinicians
The brand and marketing assessment revealed an opportunity to extend our brand into areas of applied medical learning. As we develop a plan for creating a new business around physician education, we’ll first identify shortcomings in current physician learning systems and find innovation opportunities, especially those that will appeal to practicing physicians.

The brand/marketing assessment also suggested that Journal Watch and NEJM could help one another expand their reach via “sub-branding” within a larger “master-branded” portfolio.

**NOTABLE NUMBER**

150,000 — Number of registrants for Journal Watch Physician’s First Watch, our daily clinical email bulletin for physicians, as of April 2011

**NEJM RECOGNIZED FOR TECHNOLOGY AND BRANDING EXCELLENCE**

In November 2010, NEJM’s Interactive Medical Cases won an Excellence in Interactive Innovation Award from the Massachusetts Interactive Technology Exchange (MITX). More than 88,000 interactive cases have been completed since we launched this feature at NEJM.org less than two years ago.

*Medical Marketing and Media Magazine* named the *New England Journal of Medicine* its “media brand of the year” in January 2011. Describing NEJM as “more accessible, engaging, and relevant than ever before,” the magazine lauded our flagship publication’s “multiplatform, multispecialty strategy.”
Our Society’s membership numbers continued to trend upward this year, which is a remarkable achievement in light of ongoing economic lethargy and persistent uncertainties about health care reform.

As of May 31, 2011, membership in the MMS totaled 23,274 — a 1.4 percent increase over last year.

Membership among young physicians grew by 2.5 percent, among women by 3.8 percent, and among residents by 13 percent.

While continuing our commitment to solo and small-group practices, we also responded to the steady growth of hospital-employed physicians and the consolidation of smaller practices into large medical groups with unique membership options that reflect the increasing integration of practice structures.

Following an unprecedented spike in the number of group-enrolled physicians between FY 2009 and 2010, that number continued to rise this year by 7.5 percent. Nearly 30 percent of all MMS members are currently enrolled as part of a group.

The Society’s success in group enrollment prompted the American Association of Medical Society Executives (AAMSE) to recognize us with a 2011 Profiles in Excellence Award.

Our membership retention and growth — at a time when overall participation in organized medicine is flat or declining — are evidence of our members’ appreciation for the value offered through MMS membership.

We continued to offer new tools and resources to assist physicians with their changing practice needs. These included:

- Significant member discounts on a robust and expanding lineup of continuing medical education activities (see page 14)
- Members-only white papers about alternative payment and delivery models, maximizing office workflow efficiency, and hosting and transferring EHRs
- Rapid information delivery through 14 email newsletters, including the ARRA Advisor, which updates members on government stimulus funding, meaningful use requirements, and all aspects of health information technology
- Numerous enhancements to member communication through social media, including the MMS blog, Twitter feed, and YouTube channel, plus a pilot that is boosting the Society’s LinkedIn presence

A system upgrade in the fall of 2010 made online business transactions with the MMS easier for members. And finally, the scheduled selection and launch of a new content-management system for our website in FY 2012 promises to customize messaging to meet individual members’ needs and integrate our social media channels and emerging e-communities into a single, coherent web presence.
NOTABLE NUMBERS

130,000 — Average number of emails the Society sends out each month, representing a 90 percent cost savings compared with postal distribution

1,458 — Number of people following the MMS on Twitter (as of September 19, 2011)
RESPONDING TO WHAT PHYSICIANS NEED TO KNOW...

AND HOW THEY WANT TO LEARN

In recent years, continuing medical education has experienced a broadening in both the scope of offerings and methods of delivery — a trend that continued in FY 2011. Adding to the challenge and success of programs this year was increased collaboration between the MMS and other like-minded CME providers, including the Massachusetts Medical Law Report, the American Heart Association, the Commonwealth Fund, and the Massachusetts eHealth Collaborative, just to name a few.

The MMS expanded its efforts to develop quality, jointly sponsored, live, and online activities, resulting in an increase in participation in partnered events (see table). This trend reflects our Continuing Education and Certification Department’s success in reaching out to prospective co-sponsors as continuing medical education expands from purely clinical topics to encompass issues related to the legal, technological, organizational, and leadership aspects of medicine.

Physicians’ CME needs continue to broaden, and this was reflected this year by our most-subscribed events. Among the live activities, well-attended events included a strategic payment reform summit in October 2010, a colloquium on health IT infrastructure, a symposium about transforming medical liability, and a webinar on achieving “meaningful use” of electronic health records.

Similarly, four of our most popular online activities focused on nontraditional topics: apology, advance directives, email communication with patients, and accountable care organizations (ACOs).

Some topic areas, including ACOs, were taught using multiple learning formats. For example, in addition to online learning, physicians had access to further education on ACOs through a home-study activity and most recently at an MMS-sponsored full-day conference that provided a comprehensive examination of ACO formation and function. ACO authority Harold Miller, executive director of the Center for Healthcare Quality and Payment Reform, keynoted the conference, and other renowned experts drilled down into ACO details such as risk adjustment, antitrust issues, financial considerations, and IT infrastructure requirements.

Surveys conducted throughout the year show that the MMS continues to meet the challenge of delivering new topics, providing distance learning opportunities, including live and archived webinars and vetting co-sponsors. Ninety-nine (99) percent of responding CME participants rated MMS-sponsored CME programs as “good” or “excellent” and said that the educational content was presented without bias.

In addition to direct delivery of educational activities, the MMS currently accredits 58 intrastate CME providers whose reach extends throughout Massachusetts and contiguous states.

MMS programs continue to meet rigorous standards requiring that CME improve physician competency and performance and/or patient outcomes. As traditional clinical subjects are supplemented by broader CME offerings, and as we expand joint sponsorships, meeting these standards is becoming evermore challenging, but also increasingly rewarding.
Dr. Liljestrand Receives Medical Education Award

The MMS CME enterprise owes much to its physician volunteers who serve as members of the MMS education committees. In December 2010, James Liljestrand, MD, a member of the MMS Committee on Accreditation Review and former chair of the Committee on Medical Education, received the Rutledge W. Howard, MD, Award for individual service to the intrastate accreditation system.

Dr. Liljestrand was nominated for the award by MMS President Alice A. Tolbert Coombs, MD. He was selected from candidates representing state medical societies throughout the country and accepted the award at the annual conference of the Accreditation Council for Continuing Medical Education in Chicago.

Live and Online CME Activities, FY 2011

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<th>DIRECTLY SPONSORED</th>
<th>JOINTLY SPONSORED</th>
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<tr>
<td><strong>LIVE CME ACTIVITIES</strong></td>
<td>21 (+11%)</td>
<td>31 (+35%)</td>
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<tr>
<td><strong>TOTAL EVENT ATTENDEES</strong></td>
<td>1,892 (−48%)</td>
<td>2,531 (+49%)</td>
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<tr>
<td><strong>ONLINE CME ACTIVITIES</strong></td>
<td>21 (−19%)</td>
<td>51 (+59%)</td>
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<tr>
<td><strong>TOTAL EXAMS COMPLETED</strong></td>
<td>1,123 (−4%)</td>
<td>3,204 (+55%)</td>
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Numbers in parentheses show percentage change relative to FY 2010 and document the results of MMS educational partnerships and collaborations.
This year’s public health activity focused in part on helping people rethink their approach to the treatment of viral respiratory infections. The MMS launched a multipronged campaign this past winter to combat the increased prevalence of antimicrobial-resistant bacteria and inform patients about the potential risks of unnecessary antibiotic use.

In partnership with the state Department of Public Health, and with the support of the Massachusetts Association of Health Plans, the Partnership for Healthcare Excellence, the Massachusetts Hospital Association, and Blue Cross Blue Shield of Massachusetts, we produced and aired patient-education TV ads and sent toolkits by email and postal mail to all Massachusetts practicing physicians.

The kit provided information to help physicians validate patient concerns about viral illness and included specific recommendations for symptom relief; a sample over-the-counter prescription; patient handouts explaining self-care for colds, flu, and bronchitis; and posters for office waiting rooms.

This renewed focus on treating respiratory infections was spearheaded by our committees on Public Health and Quality of Medical Practice; supported by the Public Health and Education, Communications, and Health Policy Departments; and implemented by our design, production, and distribution teams. The entire campaign was based on guiding principles developed by an expert panel organized by the Centers for Disease Control and Prevention.

On the preparedness front, the Massachusetts Department of Public Health again renewed its contract with the MMS to oversee the MA Responds program. Managed by the MMS Department of Public Health and Education and supported by many additional MMS departments and staff, MA Responds is a web-based volunteer-management system intended to ensure that the Commonwealth is prepared for health-related emergencies and events. The Society works with the DPH to recruit clinical and nonclinical volunteers, keep their data and training current, and ensure efficient mobilization during a public health emergency.
Notable Number

25 — Number of Massachusetts Medical Reserve Corps units currently participating in the MA Responds volunteer-management system

PLAY FOR HEALTH CHALLENGE WINNERS SHOOT HOOPS ON THE PARQUET

After taking in a Boston Celtics game in April, winners of the MMS Play for Health Challenge got a chance to take some shots from the fabled parquet at the TD Garden. In response to MMS-sponsored radio ads on WEEI promoting physical activity, adults who answered online questions about healthy eating and exercise entered nominee names.

FOUNDATION’S PHILANTHROPY RECOGNIZED TWICE IN ONE WEEK

Twice during a single week in November 2010, the MMS and Alliance Charitable Foundation was recognized by organizations that benefit from its philanthropy. The Foundation received a Founder’s Award from the Community Health Center of Cape Cod, to which the foundation has awarded grants totaling more than $90,000 since 2003. The Foundation also received a Philanthropist of Distinction award from the Central Massachusetts Chapter of the Association of Fundraising Professionals. The recognition arose from a nomination by the MetroWest Free Medical Program, which the Foundation has helped fund for the past two years.
LEADERSHIP

MMS AND DISTRICT LEADERSHIP 2010–2011

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RICHARD V. AGHABABIAN, MD
Vice President

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RICHARD S. PIETERS, MD
Speaker, House of Delegates

JESSE M. EHRENFELD, MD
Vice Speaker, House of Delegates

MARIO E. MOTTA, MD
Immediate Past President

MARIE-CHRISTINE RETI
Alliance President

CORINNE BRODERICK
Executive Vice President

Richard Pieters, MD; Jesse Ehrenfeld, MD; Corinne Broderick; Alice Coombs, MD; Lynda Young, MD; Deanna Ricker, MD; Richard Aghababian, MD; Peter Kang, MD
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<th>Alternate Trustee</th>
<th>District President</th>
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<td><strong>BARNSTABLE</strong></td>
<td>Anna A. Manatis, MD</td>
<td>Maryanne C. Bombaugh, MD</td>
<td>Theodore A. Calianos II, MD</td>
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<td><strong>BERKSHIRE</strong></td>
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<td>Erwin A. Stuebner Jr., MD</td>
<td>Michael S. Kaplan, MD</td>
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<td><strong>BRISTOL NORTH</strong></td>
<td>Bruce S. Auerbach, MD</td>
<td>Julia F. Edelman, MD</td>
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<td><strong>BRISTOL SOUTH</strong></td>
<td>Barry Steinberg, MD</td>
<td>Asha P. Wallace, MD</td>
<td>Kenath J. Shamir, MD</td>
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<td><strong>CHARLES RIVER</strong></td>
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<td>Nasir A. Khan, MD</td>
<td>Mohammad G. Reda, MD</td>
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<td><strong>ESSEX SOUTH</strong></td>
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<td>Stephen H. Fox, MD</td>
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<td>Mark M. Sherman, MD</td>
<td>Claudia L. Koppelman, MD</td>
<td>Robert E. Byrne III, MD</td>
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<td>Mark A. Bigda, MD</td>
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<td>Carole E. Allen, MD</td>
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<td>Peter D. Rappo, MD</td>
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<td>Cyrus C. Hopkins, MD</td>
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<td>James B. Broadhurst, MD</td>
<td>George Abraham, MD</td>
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<td>Heidi J. Foley, MD</td>
<td>Svend W. Bruun Jr., MD</td>
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**Note:**
- The list includes all the counties and their respective trustees and alternate trustees, along with the district presidents.
- The positions of the trustees include Trustee, Alternate Trustee, and District President.
- The list also includes additional roles such as Chair of Finance and Resident Trustee.
- The data is presented in a tabular format for easy readability.