

ANNUAL REPORT ACADEMIC YEAR 2025 - 2026

LEARNING ENVIRONMENT REPORT

LONG SCHOOL OF MEDICINE

Fostering a culture of confidence



Long School of Medicine
The University of Texas at San Antonio®

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Message from the Interim Dean

I am pleased to share the first Long School of Medicine Report on the Learning Environment. This report is a partnership between our Offices for Undergraduate Medical Education, Graduate Medical Education, and Faculty - reflecting our shared commitment to fostering a learning environment grounded in mutual respect, collegiality, fairness and trust for everyone on our campus.

In November 2025, the LSOM Continuous Quality Improvement Steering Committee (CQISC) authorized the production of a school-wide learning environment report. The recommendation resulted from the CQISC's ongoing monitoring of the learning environment, which included reviewing outcomes from student surveys that reflected high rates of "not applicable" responses to questions related to awareness of mistreatment prevention activities and their effectiveness and awareness that mistreatment is investigated and acted upon. The CQISC further recognized including data from resident and faculty programs would create the opportunity for larger-scale impact, and thus a partnership was formed between Offices for Undergraduate Medical Education, Graduate Medical Education, and Faculty to develop a holistic report on the learning environment.

We are so proud of the efforts of all our faculty, staff, residents and students, and look forward to bringing you updates on the actions plans described in this report.



Office for Undergraduate Medical Education

The learning environment is a central component of the medical education program. It influences whether students feel able to ask questions, acknowledge uncertainty, seek feedback, raise concerns, and develop the professional behaviors expected of physicians. Consistent with Liaison Committee on Medical Education (LCME) expectations, the Long School of Medicine (LSOM) has a responsibility to evaluate the learning environment regularly, identify both positive and negative influences, strengthen conditions that support professional development, and address conduct that falls below institutional standards.

This review brings together multiple sources of evidence to assess the undergraduate medical education learning climate during academic year 2025–2026. It is intended to provide a holistic assessment of the environment in which students learn by identifying recurring strengths, concerns, and areas of uncertainty across several complementary sources of information. Data for this report is from four principal sources:

- 2026 Learning Climate Survey (LCS): an institutionally developed survey administered to first-, second-, and third-year medical students.
- 2025 Independent Student Analysis (ISA): a confidential, student-led assessment conducted as part of the LCME accreditation process that provides feedback from students across all four years. This report includes findings most relevant to the learning climate.
- 2026 Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ): provides the perspective of students who completed the full medical education program. Selected results related to the learning environment are discussed in this report.
- AY2025-26 mistreatment and learning-environment reports: reports received through all LSOM reporting pathways, as well as the institutional processes and responses associated with those reports.

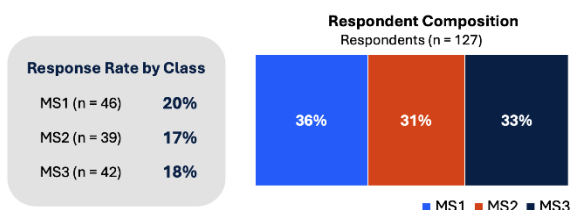
Together, these sources provide information about students' day-to-day experiences, their perceptions of institutional processes, the perspective of a recently graduated class, and the school's responses to reported concerns. Accordingly, this review emphasizes findings that converge across sources, identifies areas in which the evidence differs, and distinguishes established patterns from questions requiring continued monitoring. The review is intended to recognize and reinforce areas of institutional strength while examining concerns with appropriate candor. It establishes an initial baseline for annual review, supports institutional decision-making and continuous quality improvement, and provides a framework for evaluating whether future interventions produce meaningful and sustained change.

2026 Undergraduate Medical Education Learning Climate Survey (LCS)

In spring 2026, first-, second-, and third-year medical students were invited to participate in the first LSOM Learning Climate Survey. Fourth-year medical students were not included in this administration to avoid duplicative assessment during the administration of the 2026 AAMC GQ. This newly developed institutional instrument was designed to provide a focused assessment of students' experiences within the pre-clerkship and clerkship learning environments and establish a baseline for future annual review.

The 2026 LCS evaluated student perceptions of interpersonal respect, comfort asking questions and raising concerns, awareness of reporting pathways, confidence in institutional response, observed unprofessional behavior, personal experiences of mistreatment, inclusion, clarity and consistency of educational expectations, quality of feedback, and the overall effect of the learning environment on well-being.

The survey was available for four weeks from April through May 2026. Of 702 eligible students, 127 completed the survey, for an overall response rate of 18%. Response rates were similar across classes: 20% of MS1 students (n = 46), 17% of MS2 students (n = 39), and 18% of MS3 students (n = 42). The respondent group was relatively evenly distributed across the three classes, with MS1, MS2, and MS3 students comprising 36%, 31%, and 33% of respondents, respectively.



2026 Learning Climate Survey

Table 1 presents the percentage of respondents who selected “Agree” or “Strongly Agree” for each agreement-scale item, both overall and by class. The accompanying heat map is intended to facilitate comparison across questions and cohorts; greener shading represents higher percentages of favorable responses, while redder

Table 1: Percent of Students that Agree or Strongly Agree With Each Statement

	Overall	MS1	MS2	MS3
I feel respected by faculty.	85%	85%	79%	90%
I feel respected by residents.				88%
I feel respected by my peers.	90%	89%	95%	86%
I feel comfortable asking questions without fear of embarrassment.	71%	78%	62%	71%
I feel safe raising concerns about unprofessional behavior.	65%	72%	54%	67%
I know how to report concerns about the learning environment or mistreatment.	75%	65%	69%	90%
I believe concerns are taken seriously when reported.	54%	54%	44%	64%
I trust the school to respond appropriately when concerns are reported.	54%	54%	44%	62%
My background and identity are respected.	85%	87%	85%	83%
Faculty model respectful interactions with students.		95%	93%	
Faculty and residents model respectful interactions with students.				79%
The preclinical curriculum promotes collaboration rather than unhealthy competition.		80%	71%	
The clinical curriculum promotes collaboration rather than unhealthy competition.				64%
The methods and practices of student assessment are clear and consistent.	69%	65%	64%	79%
Expectations for performance are clear.	72%	76%	67%	74%
I receive useful feedback that helps me improve.	61%	46%	59%	81%
The learning environment supports my well-being.	65%	59%	59%	76%
Overall, the learning environment at this institution is positive.	72%	74%	62%	81%

shading represents lower percentages. Because neutral responses are not included in either the favorable or unfavorable categories, lower favorable percentages should not necessarily be interpreted as equivalent to disagreement.

Generally, the survey identifies a positive and supportive learning environment in which interpersonal respect and inclusion are relative strengths, with 72% agreeing the LSOM learning environment is positive overall.

Table 2 presents the percentage of respondents who reported that they had “Never” observed or experienced the behaviors included in the professionalism and mistreatment domain. Overall, 65% of respondents reported never having observed unprofessional behavior by faculty during the preceding 12 months. Among MS3 respondents, 48% reported never observing unprofessional faculty behavior, and 60% reported never observing unprofessional behavior by residents. Most respondents, 87%, reported never personally experiencing mistreatment; however, this percentage decreased across successive classes, from 96% among MS1 respondents to 79% among MS3 respondents.

Table 2: Percent of Student Having Never Experienced the Behavior in Each Statement

	Overall	M1	M2	M3
I have observed unprofessional behavior by faculty in the past 12 months.	65%	72%	74%	48%
I have observed unprofessional behavior by residents in the past 12 months.				60%
I have personally experienced mistreatment in the past 12 months.	87%	96%	87%	79%

Respect & Psychological Safety

Interpersonal respect represents a clear strength within the survey findings. Overall, 85% of respondents agreed or strongly agreed that they felt respected by faculty, and 90% reported feeling respected by their peers. Among MS3 respondents, who were the only students asked about residents, 88% reported feeling respected by residents.

Seventy-one percent of respondents reported feeling comfortable asking questions without fear of embarrassment, and 65% reported feeling safe raising concerns about unprofessional behavior. It is important to distinguish between these two forms of psychological safety. Some degree of hesitation in asking questions or revealing uncertainty may reflect normal academic dynamics, such as concerns about preparedness or performance. In contrast, feeling safe to raise concerns about unprofessional behavior represents a more consequential dimension of the learning environment, as it involves speaking up about issues that may carry interpersonal or hierarchical risk.

MS2 respondents reported the lowest favorable percentages on both psychological-safety items, though much of this is due to neutral rather than unfavorable responses: 26% were neutral regarding comfort asking questions, and 33% were neutral regarding safety in raising concerns. This pattern may indicate uncertainty or variability in students’ experiences rather than a consistently negative perception. Because this is the first administration of the survey, it is not yet possible to determine whether the finding reflects the experiences of this particular cohort or a recurring feature of the second year of the curriculum.

The MS3 results warrant a different form of attention, as 19% responded unfavorably regarding feeling safe raising concerns about unprofessional behavior. This may reflect differences in the clinical settings, teams, and supervisory relationships encountered by individual students. The survey cannot identify the source of that variation, but these results suggest psychological safety may not be experienced consistently across clinical environments.

Reporting & Institutional Trust

Mixed results were present within the domain of reporting and institutional trust, with approximately three-quarters of respondents reported knowing how to report a concern but only slightly more than half agreeing that

concerns are taken seriously or that the school responds appropriately when concerns are reported. These results suggest awareness of reporting pathways is stronger than confidence in the institutional processes that follow a report, and this may indicate a combination of skepticism among some students and limited visibility among students who have not reported mistreatment into what occurs after a concern is submitted.

Awareness of reporting pathways varied by class, and progressively increased with time in the curriculum, reaching 90% agreement for MS3 respondents. This higher level of awareness may reflect cumulative exposure to institutional communications and reporting processes or additional instruction associated with entry into the clinical curriculum.

Responses were less favorable when students were asked what they believed would occur after a concern was reported. Overall, just over half of respondents believed that concerns were taken seriously, and the same number trusted the school to respond appropriately. Approximately one-quarter of respondents selected a neutral response for each question. The substantial proportion of neutral responses requires careful interpretation - neutrality may indicate respondents have not used the reporting system and lack sufficient information to judge it. It may reflect limited visibility into institutional follow-through, which is necessarily constrained when concerns involve confidential student, faculty, resident, or personnel matters. Other respondents may have had mixed experiences or may be uncertain about what constitutes an appropriate institutional response. The survey cannot distinguish among these possibilities. Finally, 21% of respondents did not believe concerns were taken seriously, and 23% did not trust the appropriateness of the school's response. These unfavorable responses represent a meaningful minority and warrant further exploration. Findings from the ISA, GQ, and mistreatment-reporting review discussed later in this report provide additional context for this discussion.

Overall, the survey identified a meaningful distinction between students' awareness of reporting mechanisms and their confidence in the processes that follow. LSOM has established multiple pathways through which students may raise concerns, but the effectiveness of those pathways and ultimately their use depends on whether students understand the processes and have confidence that reports will receive serious, fair, and proportionate consideration.

Inclusion and Belonging

Perceived respect for students' backgrounds and identities represents a clear strength in the survey findings. Overall, 85% of respondents agreed or strongly agreed that their background and identity were respected and only 4% responded unfavorably. Results were relatively consistent across classes: 88% of MS1 respondents, 85% of MS2 respondents, and 83% of MS3 respondents reported favorable perceptions. This consistency suggests that respect for students' backgrounds and identities is broadly experienced across the phases of the curriculum rather than being confined to a particular cohort.



2026 Learning Climate Survey

Phase-Specific Educational Environment

Role-modeling of respectful interactions by faculty and residents was generally favorably viewed in both the preclinical and clinical phases of the curriculum, with greater than 90% agreement among MS1 and MS2 cohorts. A slight decrease in agreement was present in responses with MS3s, with nearly 80% agreement and nearly 15% disagreeing. Among pre-clerkship respondents who received the questions, 76% agreed the curriculum promoted collaboration rather than unhealthy competition, and within the limited MS3 subset 64% viewed the clinical curriculum as collaborative. Collaboration within the clinical curriculum produced a comparatively high

unfavorable response of 29%, which warrants further investigation. These phase-specific differences warrant further investigation and continued monitoring in future iterations of the survey. A technical issue in survey administration impacted implementation of phase-specific questions, and the small and nonrandom subsets do not support conclusions about the full student population. These items will be administered consistently in future surveys so that professional role modeling can be assessed more reliably.

Well-Being & Culture

This domain assessed whether the learning environment supports students' well-being and whether the learning environment is positive overall. These broad indicators of students' perceptions of the educational culture should not be interpreted as direct measures of student wellness, distress, or burnout.

Overall, 73% of respondents agreed or strongly agreed the learning environment was positive, 17% were neutral, and 11% responded unfavorably. When asked about support for their well-being, 65% of respondents agreed or strongly agreed 18% selected a neutral response, and 17% responded unfavorably. The difference between these two findings is meaningful. Students may experience an institution as respectful, collegial, and positive while remaining less certain that the conditions of their education actively support well-being. It is also important to acknowledge that some students may not expect a learning environment to support their well-being directly, instead viewing well-being as a personal responsibility or as separate from the educational structure. A positive learning environment and a learning environment that supports well-being are therefore related but not interchangeable judgments.

Perceptions varied by class, with almost 60% of MS1 and MS2 respondents agreeing the learning environment supported their well-being, compared with 76% of MS3 respondents. Unfavorable responses were reported by nearly one-quarter of MS1 and MS2 students, and only 5% of MS3 students. Regarding the overall learning environment, favorable responses were reported by 75% of MS1 respondents, 62% of MS2 respondents, and 81% of MS3 respondents reported favorable responses.

These results suggest that MS3 respondents generally experienced the learning environment more favorably than students in the pre-clerkship curriculum. This may reflect characteristics of the clinical learning environment, differences among cohorts, or other aspects of students' educational experiences. The comparatively lower assessment of the overall climate and support of well-being among pre-clerkship students warrant attention to determine whether students are responding to particular curricular practices, educational demands, interpersonal experiences, or other conditions.

Professionalism & Mistreatment

Overall, 65% of respondents reported never having observed unprofessional behavior by faculty, and 35% reported observing it at least once. Of these students, 17% reported observing the behavior more than once or frequently. Responses again varied substantially by curricular phase, with just over one-quarter of MS1 and MS2 respondents reporting observing unprofessional faculty behavior at least once, compared with 52% of MS3 respondents. MS3 respondents were asked about faculty and resident unprofessionalism. While 24% reported observing faculty unprofessionalism more than once or frequently, 21% reported observing it from residents more than once or frequently, and 60% reported never observing unprofessional behavior from residents.

When asked about experiences of mistreatment, most respondents (88%) reported they had not personally experienced mistreatment during the preceding 12 months and 12% reported experiencing mistreatment at least once. These findings differed by class: 3% of MS1 respondents, 13% of MS2 respondents, and 21% of MS3 respondents reported at least one experience of mistreatment. Among MS3 respondents, 19% reported experiencing mistreatment more than once.

The greater frequency of observed unprofessional behavior than personally experienced mistreatment is not unexpected. Unprofessional behavior may include conduct that does not meet the respondent's threshold for mistreatment, conduct directed toward another student or member of the health care team, or behavior involving patients or staff. The questions may also reflect different events. The survey does not permit these possibilities to be distinguished. Similarly, higher rates reported by MS3 students may reflect greater exposure to multiple clinical settings, teams, professions, and hierarchical relationships. They may also reflect cohort-specific experiences or differences in who elected to respond to the survey. As this was a cross-sectional assessment, the findings do not establish that exposure necessarily increases as individual students progress through the curriculum.

Overall, this domain identifies the clinical learning environment as the principal setting for continued attention. Future survey administrations should preserve the distinction between observed unprofessional behavior and personally experienced mistreatment while considering additional questions that clarify the setting, source, and nature of reported experiences. These findings should also be considered alongside clerkship evaluations, teaching evaluations, and formal mistreatment reports to determine whether concerns cluster in particular settings or represent broader patterns.

Conclusions

Findings from the 2026 LCS should be interpreted within the limitations of the survey. Participation was low, respondents may differ systematically from students who did not participate, and technical errors affected the administration of some phase-specific items. The survey is therefore best understood as an institutional baseline and a source of signals for further inquiry rather than definitive of the experience of every LSOM student.

Generally, the 2026 LCS provides a favorable, though differentiated, assessment of the LSOM learning environment. The results support preserving and reinforcing LSOM's broadly respectful and inclusive interpersonal culture while directing attention to four areas: confidence in institutional follow-through after concerns are reported, psychological safety in raising concerns, the usefulness of pre-clerkship feedback, and reported exposure to unprofessional behavior and mistreatment in clinical settings. Findings from the ISA, GQ, and formal mistreatment-reporting process in the sections that follow should be used to determine whether these patterns converge across sources and to guide appropriately targeted institutional responses. These findings should be considered alongside clerkship evaluations, teaching evaluations, and formal mistreatment reports to determine whether concerns cluster in particular settings or represent broader patterns.

2025 Independent Student Analysis

The ISA is a confidential, student-led evaluation conducted as part of LSOM's LCME reaccreditation process. Although it examines the medical education program more broadly than the learning environment alone, selected quantitative items and free-text responses provide useful evidence regarding institutional support, mistreatment prevention and reporting, communication, and students' confidence in institutional processes.

The ISA was administered to all enrolled medical students in fall 2025. A total of 817 students participated, representing an overall response rate of 87.0%. Students from all four classes were included, with class-specific response rates ranging from 75.9% among MS4 students to 97.1% among MS2 students. The breadth of participation is a particular strength of this source and provides an important comparison with the more focused but lower response 2026 LCS.

Quantitative Findings

As with the LCS, quantitative results of the ISA demonstrate a progression from relatively strong awareness of institutional policies and procedures to less certainty about institutional effectiveness and follow-through. Overall, 83.0% of respondents agreed that the medical school's mistreatment policy is clear, 79.8% reported knowing the procedures for reporting mistreatment or where to find them, and 74.3% were aware of the school's activities to prevent mistreatment.

Agreement decreased when students were asked to evaluate processes that are less directly visible; 63.3% agreed LSOM's activities to prevent mistreatment are effective, while 33.5% selected N/A (defined for the ISA as not applicable/no opportunity to assess), and only 3.2% disagreed. Similarly, 54.5% agreed that LSOM investigates reports of mistreatment, 42.4% selected N/A, and again only 3.2% disagreed that LSOM investigates reports of mistreatment.

These findings require careful interpretation. High N/A responses to questions concerning effectiveness and investigation should not be equated automatically with dissatisfaction. Some students may have had no direct experience with reporting, not known enough about confidential institutional processes to judge them, or they understood the questions as inapplicable to their experience. At the same time, the findings demonstrate a substantial proportion of students lacked sufficient information or experience to affirm that prevention activities were effective or that reports were investigated. Low disagreement on these items is reassuring but does not alone establish broad confidence in the processes.

MS2 respondents had the lowest agreement and highest N/A across all five ISA mistreatment-related items. As the same cohort reported less favorable perceptions across several domains of the 2026 LCS, this convergence warrants continued attention. The available evidence does not yet establish whether the pattern is specific to this cohort or reflects a recurring feature of the second year of the curriculum.

Qualitative Findings

The 2025 ISA Committee added an option for free-text response for each domain of the ISA. These responses give additional context to the ISA responses but should be interpreted in context. Students were not required to add comments and responses were collected by survey domain rather than by individual question, thus these comments alone cannot be used to estimate how commonly a particular experience occurred. They also reflect students' perceptions and, where individual incidents are described, should not be interpreted as independently verified findings. Their principal value is in identifying recurring themes and illustrating how students understand their experiences.

As seen in the LCS, respondents to the ISA indicated a strong sense of community and personal support. Students described a collaborative peer culture, approachable faculty, and staff members who demonstrated genuine investment in their success. These comments reinforce the finding from the LCS that respectful relationships and interpersonal support are meaningful strengths of the LSOM learning environment. Another theme from the ISA concerns the closing of feedback loops. Students distinguished between receiving a response and seeing evidence that a concern had been considered, acted upon, or formally resolved. It is possible that students may interpret "respond" to mean "act on" rather than acknowledging an issue, and would prefer updates when institutional work is occurring. Other students may have been indicating concerns were acknowledged but the subsequent decision, action, or rationale was not apparent to them or in some cases not their desired outcome.

Conclusions

Generally, the ISA describes an institution with substantial relational strengths but less consistent confidence in organizational responsiveness and follow-through. Many students feel personally known, supported, and connected to faculty, staff, and peers. At the same time, some students perceive variability in access, communication, and receptiveness, and many lack sufficient visibility to judge how the institution prevents mistreatment or responds after concerns are raised. The institutional opportunity is therefore not simply to create additional reporting pathways, but to improve the consistency of students' interactions and communicate the review, disposition, and aggregate outcomes of concerns more clearly while preserving necessary confidentiality.

2026 AAMC Graduation Questionnaire (GQ)

The AAMC administers the GQ annually to students graduating from U.S. MD-granting medical schools. It provides an anonymized retrospective assessment of students' experiences across the full medical education program and permits comparison with national results. Domains relevant to this review include the learning environment, student–faculty relationships, professional role modeling, personal and professional development, and experiences with negative behaviors and institutional reporting processes.

This review includes selected findings from the 2026 GQ. The questionnaire was administered from February through June 2026 to students graduating during AY2025–2026. A total of 164 LSOM students responded to the 2026 GQ, a response rate of 79.6%. Item-level respondent counts varied because not every respondent answered every question and some questions were presented only to students whose prior responses made them eligible.

Learning Environment & Student-Faculty Interaction

The GQ includes two subscales derived from a shortened version of the Medical School Learning Environment Survey. Higher scores indicate more favorable perceptions of the learning environment. The emotional-climate subscale assesses the extent to which the educational experience contributes to a sense of achievement, self-worth, and confidence in one's academic abilities. Scores range from 0 to 15 and in 2026, the LSOM mean was 10.6 compared with a national mean of 10.7. The student–faculty interaction subscale assesses perceived distance between students and faculty, and the extent to which students feel faculty are helpful in providing academic advice, nonacademic advice, answers to questions, and constructive criticism. Scores range from 0 to 20 and in 2026 the LSOM mean was 14.3, compared with a national mean of 14.9.

Professional role-modeling items provide a more differentiated picture. 54% of LSOM respondents reported disconnects between what they were taught about professional behavior and what they observed from faculty occurred never or almost never, 24% reported such disconnects sometimes, and 22% reported them fairly often or more frequently. Responses concerning resident behavior were broadly similar. These results were generally comparable to national findings and do not suggest a pervasive disconnect between formal professionalism expectations and observed behavior.

Mistreatment Policies & Reporting

As seen in the LCS and ISA, awareness of the mistreatment policy was very high, with 98.7% agreeing LSOM has policies concerning the mistreatment of medical students compared to 98.3% nationally. Knowledge of reporting procedures was lower: 86.7% of LSOM respondents knew how to report mistreatment, compared with 93.9% nationally. The findings suggest students were nearly universally aware that institutional policies existed, while a smaller but meaningful proportion did not know the procedures for using them.

The GQ also asked students if they experienced certain specified negative behaviors, the frequency of these experiences, whether they reported those behaviors and, when applicable, to whom they reported and how satisfied they were with the outcome. Just under one-third of LSOM respondents indicated they personally experienced one or more of the behaviors asked about, excluding publicly embarrassed, a rate comparable to the national average.

Eleven LSOM respondents indicated they reported their experience(s) of negative behaviors, all of whom answered the outcome-satisfaction question. Five respondents were very satisfied or satisfied, two were neutral, and four were dissatisfied or very dissatisfied. As the denominator is small, these percentages should be interpreted cautiously. Among 49 respondents who indicated that there were incidents they did not report, the most commonly selected reason was that the incident did not seem important enough to report (57.1%). Other reasons cited included they did not believe anything would be done (42.9%), fear of reprisal (26.5%), they resolved the issue themselves (24.5%), and they did not know what to do (8.2%). Respondents could select more than one reason.

Conclusions

The 2026 GQ portrays a learning environment in which graduating students generally viewed faculty relationships and the emotional climate favorably and similarly to students nationally. At the same time, the professionalism and reporting findings introduce important qualifications. Policy awareness was nearly universal, but knowledge of reporting procedures was lower than the national benchmark. Among the small number of respondents who reported negative behavior and evaluated the outcome, satisfaction was limited. Among those who did not report, concerns that no action would be taken and fear of reprisal were substantial, although neither was the most frequently selected reason.

The principal institutional implication is not that reporting mechanisms are absent. Rather, the findings suggest a need to maintain clear reporting education, examine the experience of students who use the reporting process, and strengthen confidence that concerns receive serious, fair, and proportionate consideration. Communication about aggregate processes and outcomes may improve visibility into institutional follow-through, but communication alone should not be presumed to account fully for unfavorable perceptions. Continued review should also consider the accessibility, responsiveness, and perceived fairness of the reporting process itself.

LSOM Student Mistreatment Reporting and Monitoring

Academic year 2025–2026 brought a change in LSOM’s approach to reporting and reviewing concerns involving the learning environment. Previously, mistreatment and nonacademic grievances were addressed within a single policy and process. During AY2025-26, the school established separate [Learning Environment and Student Mistreatment](#) and [Non-Academic Grievance](#) policies. This distinction allowed a student to report a concern involving the learning environment without necessarily initiating a formal grievance.

Reporting mechanisms were expanded concurrently. Prior to AY2025-26, students could raise concerns through end of clerkship, faculty, and resident evaluations or by communicating directly with the Office of Student Affairs, curricular leaders, or other institutional officials. In AY2025-26, as a result of feedback from the ISA Student Committee, mistreatment questions were added to pre-clerkship module evaluations, extending routine surveillance beyond the clinical curriculum. An independent web-based reporting portal was also implemented based on student feedback regarding the need for anonymous reporting options. This portal allows students, or any member of the medical education community, to submit concerns outside the timing of an evaluation and, when desired, without identifying themselves. Individuals submitting a report through any of these mechanisms may request follow-up or indicate they did not wish to be contacted or pursue the matter further.

These changes were intended to lower the threshold for reporting a concern, distinguish reporting from the initiation of a formal grievance, and provide the institution with a more complete view of the learning environment. They also created a more structured annual record through which reports, institutional responses, and possible patterns may be reviewed.

AY2025-26 Mistreatment Reporting

Action is taken on mistreatment and learning environment reports as soon as they are received, and quarterly updates on reports and actions are provided to the LSOM Curriculum Committee which is charged with monitoring the learning environment. In AY2025-26, 33 reports of student mistreatment were received. Upon investigation, two reports were determined to have been accidental selections on evaluation forms, resulting in 31 reports of mistreatment received for AY2025-26. All 31 incidents were investigated by the Associate Dean for Student Affairs in partnership with course, clerkship, and departmental leadership as appropriate. At the time of this report, 30 investigations are considered closed based on actions taken by these entities.

End of course/clerkship evaluation systems remained the principal reporting pathway. Of the 31 reports received, 29 originated through course, clerkship, faculty, or resident evaluations, while two were submitted through the web-based mistreatment-reporting portal. The use of multiple pathways is encouraging, although the distribution demonstrates that routine educational evaluations continued to account for most reports during the first year of the revised reporting system.

Twenty-five report entries were associated with clinical courses or electives, while six arose from pre-clerkship modules. This distribution is consistent with the LCS finding that clinical students reported greater exposure to unprofessional behavior and mistreatment. While it is important to note the difference between mistreatment reports by curricular phase, a direct comparison of incidence between the two is not possible, as clinical and pre-clerkship environments differ in duration of exposure, number of educators encountered, evaluation frequency, and opportunities for reporting.

Types of Mistreatment Reported

When making a report, types of mistreatment experienced are determined based on a description of the incident(s). As such, a single report could involve, for example, both physical contact and loss of personal civility or both derogatory language and public humiliation. Therefore, the category counts provided below describe the content of the reports but should not be summed to calculate the total number of events.

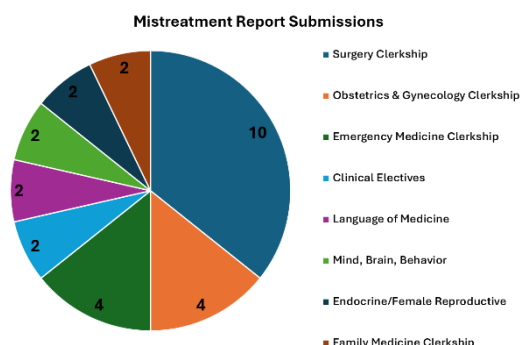
Loss of personal civility was the most common classification, appearing in 17 reports. These concerns included belittling, public humiliation, displays of temper, condescension, profanity, and aggressive or discouraging communication. Other concerns reported involved offensive remarks/names about groups; assessment or feedback perceived as unrelated to performance; physical contact or threatened physical contact; sexual harassment; and requests or errands unrelated to learning or patient care.

Distribution Across Courses and Settings

Course-level counts should be interpreted cautiously. They have not been adjusted for the number of students rotating through each course, the duration or intensity of clinical exposure, the number of faculty, residents, or other health professional encountered, or the number of evaluations completed. They therefore identify areas for attention but do not constitute comparative mistreatment rates. In some cases, multiple reports were received for the same incident, or reported incidents were directed at residents or other members of the medical education community, highlighting the vigilance of LSOM students to identify incidents impacting the learning environment which they have observed but not themselves experienced. The concentration of reports in a given

department should not be characterized as evidence of a single repeat offender, indeed no reports were received for the same individual across any course or setting, but it remains an important setting-level signal that warrants continued monitoring.

The surgery clerkship had the largest number of received reports with ten of the 31 reports. Obstetrics and Gynecology and Emergency Medicine each had four; Family Medicine had two; Medicine, Neurology, and Psychiatry each had one report; and no mistreatment reports were received for the Pediatrics clerkship. The remaining 7 reports were distributed among other clinical courses/electives, and pre-clerkship modules.



Institutional Response and Closure

At the time of this review, 30 of the 31 report entries were closed and one remains open pending continued investigation and institutional response. Closure indicates that the report had been reviewed and that the available response had been completed or transferred to the responsible educational, departmental, program, or clinical-site leadership. It does not necessarily mean that the reported conduct was substantiated, that the student was satisfied with the outcome, or that no further monitoring was required. The remaining open report was received at the end of the academic year and the investigation is ongoing.

Responses varied according to the information available, the nature of the concern, the student's preferences, and whether the individual involved could be identified. Actions included contacting and meeting with students, review by course and clerkship directors, referral to department chairs and residency program leadership, direct feedback or coaching, developmental planning, broader education of clinical staff, review through a clinical competency committee, 360-degree assessment, and continued monitoring of evaluations.

In several cases, individual intervention was limited because the report did not identify the faculty member, resident, or staff member involved. In others, the reporter declined follow-up or requested that the matter not be escalated. These requests were documented, and reports were referred for monitoring where more specific action was not possible. When an individual and setting could be identified, the documented responses were generally more direct and included feedback, coaching, leadership review, or a formal developmental intervention.

No confirmed repeat offender was identified during the reporting period. In that context, a predominantly developmental and monitoring-oriented approach was reasonable. The absence of an identified repeat offender, however, should not preclude attention to clustering by course, setting, professional role, or type of behavior. Continued annual review will be necessary to determine whether currently isolated reports become recurring patterns.

Conclusions

The evidence reviewed in this report supports a generally favorable but differentiated assessment of the LSOM undergraduate medical education learning climate. Across multiple sources, students described respectful interactions with faculty, residents, and peers; a supportive and collaborative community; and generally favorable relationships with faculty. Most respondents viewed the learning environment positively, and 2026 GQ findings concerning emotional climate and student–faculty interaction were close to national benchmarks. These findings identify interpersonal respect, inclusion, collegiality, and personal support as important institutional strengths that should be preserved and reinforced.

Though the data presented demonstrated high awareness across sources that mistreatment policies existed, evidence was less consistently favorable when students were asked whether they felt safe raising concerns, reported concerns would be taken seriously, and the school would respond appropriately. The ISA similarly identified limited student visibility into the disposition of student feedback. Less complete knowledge of reporting procedures, limited satisfaction among the small number who evaluated reporting outcomes, and concern among some students that reporting would not produce action or could result in reprisal all warrant further investigation.

These findings should not be interpreted to mean that LSOM lacks reporting mechanisms or institutional response processes. During AY2025–26, the school separated mistreatment reporting from the nonacademic grievance process, expanded reporting pathways, implemented routine surveillance in both pre-clerkship and clinical evaluations, and established a structured process for review and quarterly reporting. Thirty of 31 mistreatment reports were investigated and subsequently closed, indicating the revised process was operational and that concerns generally moved through the expected institutional pathways.

At the same time, procedural closure should not be equated with outcome effectiveness, student satisfaction, or prevention of recurrence. The reporting data demonstrates institutional activity, while the survey evidence demonstrates that this activity is not uniformly visible or trusted by students. The principal institutional challenge is therefore both operational and relational: LSOM must continue to ensure that concerns receive serious, fair, timely, and proportionate consideration while also communicating the reporting process and aggregate outcomes more clearly within the limits imposed by confidentiality and due process.

The review identified additional areas requiring attention. Pre-clerkship students expressed more mixed perceptions of whether the learning environment supported their well-being and in the clinical curriculum, MS3 respondents reported favorable perceptions of the overall environment but the greatest exposure to unprofessional behavior and mistreatment. Formal reports were similarly concentrated in clinical settings. These findings do not support a conclusion that the clinical environment is broadly negative but do indicate professionalism and mistreatment should remain priorities for clinical educational leadership.

Findings from the LCS, ISA, and GQ demonstrate that the existence of the work to prevent, monitor, and address student mistreatment is not uniformly visible to students. Many students remain uncertain whether concerns are taken seriously, investigated, or followed by appropriate action. The operational evidence in this section does not invalidate those perceptions. Rather, it suggests a gap between the work performed within the institutional process and what students are able to observe or understand about that process.

The institutional priority is therefore twofold. LSOM and OUME should continue to strengthen the consistency, documentation, and evaluation of its responses to individual reports while also improving communication about how concerns are reviewed, the range of actions that may follow, and the aggregate outcomes of the reporting process. Such communication must preserve the confidentiality of reporters and respondents, and the privacy and due-process interests of the individuals involved. Within those constraints, closing the feedback loop is essential to building confidence that reporting results in serious, fair, and proportionate institutional consideration.

Implementation of these priorities should occur through the existing governance structure of OUME, department educational leadership, and the Curriculum Committee. For each priority, the responsible group should identify specific actions, expected completion dates, and measures of progress.

Graduate Medical Education

The Office of Graduate Medical Education (OGME) maintains a comprehensive and data-driven system to monitor, assess, and improve the clinical learning environment across more than 90 residency and fellowship programs and multiple participating clinical sites. This system incorporates annual ACGME Resident and Faculty Survey results, an anonymous, institution-wide Clinical Learning Environment (CLE) Survey, Annual Institutional Review (AIR) findings, Institutional WebADS review, and feedback from the Graduate Medical Education Committee (GMEC). Data are routinely reviewed through institutional governance structures and used to identify strengths, address concerns, and guide continuous improvement efforts.

Recent results demonstrate positive trends in key learning environment domains, particularly professionalism, confidential reporting, and learner engagement. The AY2024-2025 AIR Executive Summary reported overall improvement across Accreditation Council for Graduate Medical Education (ACGME) Faculty Survey domains, including professionalism, patient safety, teamwork, evaluations, educational content, and institutional resources. Faculty reported exceptionally high performance in confidential reporting processes, with performance reaching 99%.

The OGME learning environment strategy is built upon three complementary pillars:

1. Proactive identification and support of learners through the transition to residency and throughout training
2. Robust monitoring of the clinical learning environment
3. Multiple confidential mechanisms for raising concerns and promoting professionalism concerns

Together, these efforts create a culture focused on learner well-being, psychological safety, professionalism, and continuous improvement.

Proactive Learner Support and Well-Being Programs

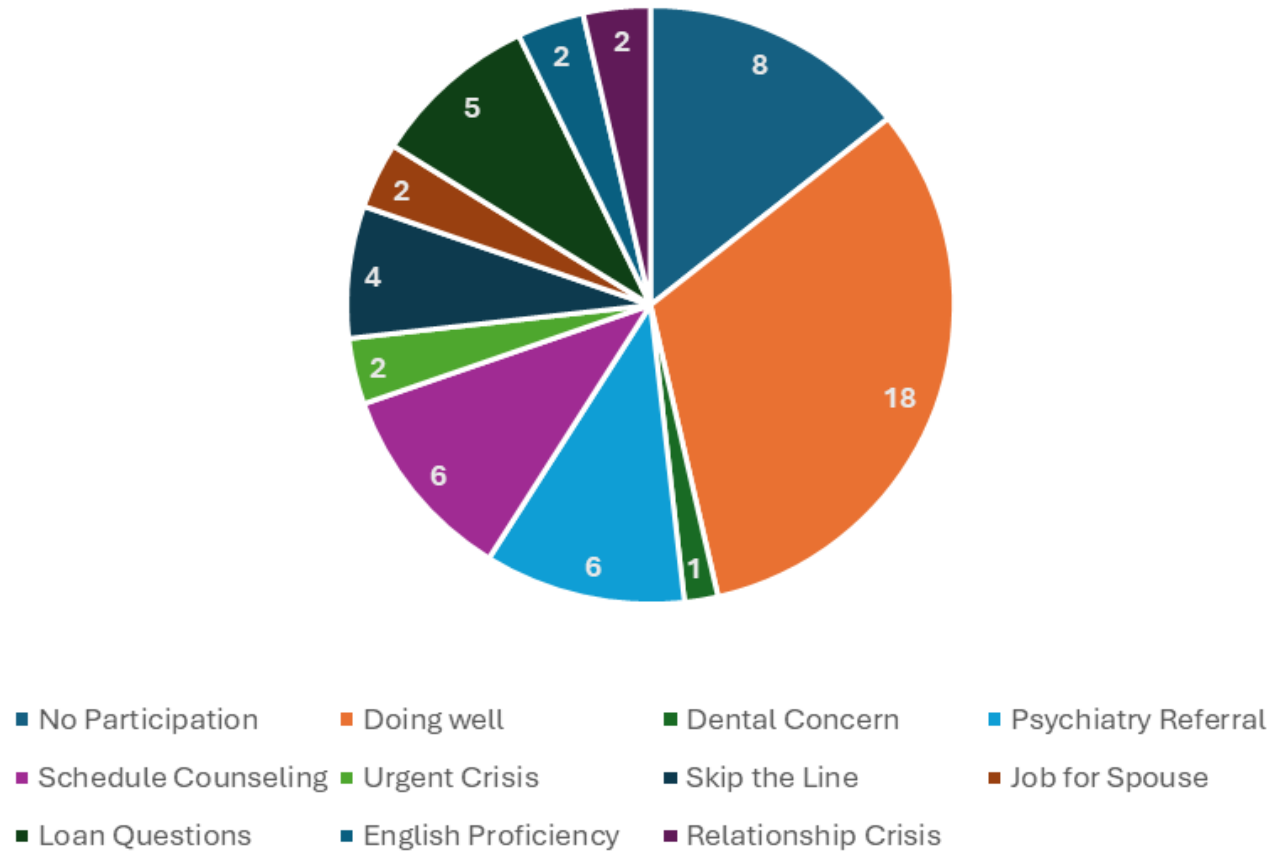
A major institutional strength is the comprehensive approach to resident and fellow well-being led by the OGME Wellness and Work-Life Action Committee. The committee oversees multiple initiatives designed to promote resilience, identify learners who may be struggling, and provide support before concerns escalate into significant personal or professional difficulties. These programs reflect OGME's philosophy that learner well-being is an essential component of patient safety, professionalism, and educational excellence.

The Transition to Residency Risk Index (TRRI) was developed to identify incoming interns who may be at higher risk for challenges during the transition from undergraduate medical education to graduate medical education. The tool facilitates early awareness and support for incoming residents while helping programs engage learners proactively. Institutional reports note that 11% of incoming interns who complete the assessment are identified as high-risk each year. The institution reports increasing partnerships, utilization, and scholarship of the TRRI when compared to other programs nationally.

The GME Wellness Home provides comprehensive support beyond traditional counseling services. Residents and fellows may receive assistance related to mental health concerns, financial stressors, visa issues, family concerns, and transition-to-practice challenges.

Circle of Care provides structured check-in meetings for trainees and connects learners with additional support and resources when needed. More than half of Circle of Care encounters result in meaningful follow-up interventions, including counseling or psychiatry referrals, crisis support, and other supportive services. In 2025, 54% of residents attending Circle of Care visits required additional support or counseling. See Figure 2 for additional information on outcomes from 2025 Circle of Care programming.

Figure 2. 2025 Circle of Care Outcomes, n= 56



Domain Pulse Checks provide ongoing assessments of learner well-being and help residency programs identify emerging concerns before they negatively impact the educational environment.

Residents and fellows struggling in the clinical learning environment receive resources through the Resident Achievement Program. Resources are available in the six competency domains: medical knowledge, patient care, communication and interpersonal, practice-based learning, system-based practice and professionalism. In AY2024-25, OGME worked with 12 individuals over a total of 25 meetings to provide professional support, mentorship, and advocacy to their programs.

Monitoring the Clinical Learning Environment

The OGME utilizes multiple complementary approaches to monitor the learning environment and evaluate institutional performance. A cornerstone of these efforts is the institution's annual anonymous Clinical Learning Environment (CLE) Survey. The survey is administered across residency and fellowship programs and provides valuable information regarding professionalism, psychological safety, learning environment concerns, reporting pathways, and overall trainee experience. Results are used alongside institutional reviews, Special Program Reviews (SPRs), ACGME survey data, and GMEC oversight activities to develop action plans.

The CLE Survey evaluates important dimensions of the learning environment, including:

- Ability to raise concerns without fear of retaliation
- Awareness of reporting pathways
- Professionalism within the clinical learning environment

- Experiences with disrespectful or disruptive behavior
- Educational and clinical site experiences
- Program satisfaction and engagement

This level of detail allows the institution to distinguish individual, programmatic, and site-based concerns and facilitates more targeted interventions. The institution routinely reviews survey findings to identify trends, monitor progress over time, and guide targeted interventions. Programs demonstrating opportunities for improvement receive focused attention through existing oversight and quality improvement processes.

Clinical Learning Environment Survey

Recent CLE Survey findings demonstrate encouraging results regarding psychological safety and reporting culture. Approximately 87% of respondents indicated they were comfortable raising concerns without fear of penalty or retribution, while 72.2% reported awareness of mechanisms outside their training program for raising concerns, and nearly 90% would recommend the LSOM clinical environment for training or employment after completing residency or fellowship. These data are monitored over time and incorporated into institutional, participation site, and program-level action planning processes.

Annual Institutional Review

The AY2024-2025 AIR Executive Summary demonstrated overall improvement across ACGME survey domains, including professionalism, from the previous year. ACGME survey data indicate that 79.2% of respondents felt they were able to raise concerns without fear of intimidation or retaliation, and encouragingly, 91.2% indicated they were aware of processes in place for confidential reporting of unprofessional behavior. When asked about the professionalism of faculty, 90.5% reported faculty members act professionally when teaching, and 96.0% reported faculty act professionally when providing care. In addition, 95% of residents and fellows reported not having experienced abuse, harassment, mistreatment, discrimination, or coercion, and a similar percentage reported not having witnessed it. This survey demonstrates exceptionally strong performance in confidential reporting processes, as well as promoting and maintaining a respectful learning environment.

Actions to Improve the Clinical Learning Environment

LSOM OGME utilizes a continuous improvement approach that emphasizes both prevention and accountability. OGME reviews learning environment concerns through established governance structures and incorporates them into AIR action planning, GMEC review, committee activities, and participating site discussions. In AY2024-25 OGME reviewed environmental concerns within two departments and four divisions based upon resident concerns or complaints. In each instance, recommendations were made and substantive changes occurred in most of those programs.

In response to feedback that reporting processes are sometimes difficult to understand, OGME developed new and enhanced existing avenues through which residents and fellows may report concerns. These include revising the Resident Concerns Policy; updating orientation resources and reporting information; provision of the “Pink Card” along with their badges to all residents and fellows that includes reporting information and contact, this resource is routinely stressed to programs, particularly if CLE survey data indicates a lack of awareness for reporting methods outside of the program; and developing web-based reporting resources and placement on the GME website. This is in addition to existing mechanisms by which learning environment concerns may be shared by residents and fellows, including through the House Staff Council, OGME leadership and staff, institutional compliance pathways, ACGME reporting options, and the previously discussed annual anonymous CLE Survey.

Residents are reminded of these pathways at orientation and throughout training. The effectiveness of reporting mechanisms is assessed through institutional surveys and annual review processes.

The institution's emphasis on confidential reporting, psychological safety, and professionalism aligns with a broader commitment to ensuring that learners can seek assistance, report concerns, and participate fully in educational activities within a respectful clinical learning environment.

Conclusions

In recognition of the opportunity presented by a comprehensive learning environment report, OGME cross-referenced CLE Survey data with known focus areas of the ISA and OUME LCS. This analysis identified CLE questions that overlap with ISA questions and could serve as a proxy for those questions among residents. Figure 3 contains the results of this analysis.

Figure 3. GME Crosswalk of UME and CLE Survey

UME theme	CLE evidence	Alignment	Favorable	Concern	Interpretation/gap
Mistreatment policy known and clear	No direct CLE question	Gap	—	—	Add item on awareness and clarity of the mistreatment policy.
Process for reporting and where to find it	Q20: awareness of avenues outside the program	Partial	72.2%	27.8%	72.2% are aware; CLE does not ask whether respondents know where the process is located.
Procedures for reporting are known	Q6: know whom to contact to raise a concern	Proxy	87.8%	12.2%	Contact knowledge strong, but Q6 is framed around inadequate supervision rather than mistreatment.
Institutional prevention activities known	No direct CLE question	Gap	—	—	Add item asking whether prevention activities and training are known.
Prevention activities are effective	Q8: no disrespectful/disruptive behavior witnessed or experienced	Proxy	65.4%	34.6%	Outcome proxy only; site results vary materially and do not measure knowledge or perceived effectiveness of prevention activities.
Program/institution investigates and acts	Q19: concerns addressed within program without intimidation/retaliation	Partial	86.7%	13.3%	Strong program-level confidence; CLE does not directly ask if institution investigates/takes action.
Feel safe and secure in the institution/CLE	Q5: no inadequate supervision; Q17/Q18 environment recommendations for training & future job	Proxy	89.6%	10.4%	Clinical-safety and climate proxies favorable overall, but no explicit safe-and-secure item. However, recommending the environment as a place to train or work is fairly good proxy.

Several areas of overlap in terms of the questions asked were identified and responses to some of these questions followed similar patterns as OUME learning environment data. This presents an opportunity for continued collaboration and enhancement of the LSOM learning environment. To further support these efforts, OGME has determined to add CLE Survey questions that address the identified data gaps with the OUME survey data, particularly determining awareness and clarity of mistreatment policies and awareness of prevention activities.

LSOM OGME has developed a mature and integrated approach to fostering an effective clinical learning environment. Through proactive wellness initiatives, nationally recognized transition-to-residency efforts, robust professionalism programs, annual anonymous learning environment assessment, multiple confidential reporting pathways, and strong institutional oversight, the organization demonstrates a sustained commitment to supporting learners and continuously improving the educational environment.

The resulting culture emphasizes professionalism, psychological safety, learner well-being, accountability, and continuous improvement, benefiting medical students, residents, fellows, faculty, and healthcare teams who learn together within the institution's clinical learning environments.

Office for Faculty

Faculty excellence is a key part of optimizing the LSOM Learning Environment; when faculty are highly engaged in rewarding academic careers, the learning environment is likewise vibrant and thriving. The LSOM Office for Faculty (OFF) supports faculty across the full career lifespan—from hiring and launch through growth and retirement. Providing reliable structures, expert guidance, and responsive resources to LSOM departments, centers, and institutes, OFF helps faculty focus their energy on teaching, development, scholarship, and creating a supportive learning environment. OFF programming is dedicated to ensuring quality, integrity and continuous improvement in three main areas: personal and professional faculty support processes, faculty career development and advancement, and the multifaceted faculty wellness and well-being program. Embedded concepts are life-long learning, interpersonal respect, humanism, burn-out prevention and well-being promotion, iterative quality improvement and anticipatory guidance in faculty career development.

Supportive Faculty Processes for Educational Excellence

Consistent high-quality operational support allows academic home departments and administrative home centers and institutes to recruit, hire, launch, guide, grow, and retire talented, productive faculty members with efficiency. These processes are continuously monitored to ensure the integrity of faculty-related processes. As a result, these reliable systems reduce stress, uncertainty, and administrative distraction, allowing faculty and leaders to focus on aligning their roles with the learning environment and responding to learner needs without distraction from administrative process details of their careers.

Faculty Career Development Builds Stronger Educators and Leaders

An important part of the LSOM faculty role is role-modeling for learners across the breadth of our institution's teaching and learning sites to enrich professional identity development. OFF provides overarching career development materials, programs, resources, and outreach, including awareness of professional-development opportunities available throughout the institution. These efforts help faculty build the knowledge, skills, networks, and recognition needed to excel as educators and leaders. Better-prepared educators and leaders strengthen teaching quality, role modeling, mentorship, collaboration, and a culture of educational excellence. Examples of programming available through LSOM include:

- **Academy of Educational Scholars (AES):** AES supports teaching excellence through building a thriving LSOM community of practice. OFF co-developed AES with the LSOM Department of Medical Education and provides continuing support for AES to advance teaching excellence, educational scholarship, mentorship, and career development for medical educators. AES membership is an outcome of a year-long LSOM faculty fellowship training to jumpstart academic educator career development and retain these faculty. Five cohorts of AES Fellows have been inducted to date, aligned with the AES goal of building a network of LSOM educators that share best practices, innovative educational methods, materials, programs, and resources.
- **Introduction to Leadership:** OFF co-developed this course with the Department of Medical Education that equips faculty and administrative staff with practical tools, skills, and resources for effective leadership, which in large part is communicating effectively. Held semi-annually, OFF provides continuing support for this important resource.

Faculty Well-Being Sustains a Healthy, Supportive Culture

OFF advances faculty well-being through a multi-pronged, outcomes-focused approach that combines accessible resources, timely care, peer support, engagement data, and organizational improvement. Faculty who feel supported and have access to effective resources are better positioned to create a healthier environment for themselves as well as learners. In addition to connecting faculty with institutional and HR wellness resources, OFF programming includes career-progression and financial-wellness materials as well as the following:

- **Faculty Well-Being app:** provides free wellness resources, self-screener for burnout, and links to behavioral health services, including self-referral.
- **LSOM Faculty Behavioral Health Clinic:** founded in 2023, this clinic provides rapid access for faculty and staff to psychologist counseling at copay cost only.
- **Peer networks and communication:** LSOM Well-Being and Professionalism Champions support local engagement, reinforced by monthly newsletter and quarterly meetings.
- **Educator recognition:** LSOM has two school-level mechanisms for recognizing faculty for their educational excellence, including the AES Star Educator recognition originating from learner and peer nominations, and the annual Master Educator Awards, recognizing both OUME preclinical education and clinical educator excellence, which are peer-selected from among the nominees.

Monitoring Faculty Perceptions of the Learning Environment

The American Medical Association Joy in Medicine Organizational Biopsy Survey, AAMC StandPoint Faculty Engagement Survey, and StandPoint Champions are systems used by OFF to inform outcomes-focused improvement. The AMA Joy in Medicine Health System Recognition Program recognizes organizations for dedication to building well-being and reducing physician burnout. OFF's support of the AMA Joy in Medicine Program has resulted in sustained Bronze-level recognition, most recently awarded in 2023 with recognition expected again in October 2026. EPIC electronic health record improvements are already supporting LSOM's reach for a greater level of recognition.

The AAMC StandPoint Faculty Engagement Survey (SPS) is a research-validated customizable faculty engagement survey that can be used by LSOM leadership and the faculty body to understand workforce needs and direct resourcing to areas most in need. These confidential surveys also include nationwide benchmarking data to support data-driven decision-making in domains that include workplace culture, opportunities for career and professional growth, collegiality and collaboration, and overall engagement. Last conducted in November 2021, the SPS was used to understand faculty perceptions of LSOM, including satisfaction with the learning environment, faculty well-being, and burnout. The 69.9% response rate was well above the national average.

Burnout and wellness were assessed by two embedded and validated measures. Unit-based ‘champions’ helped establish school and department-level Action Task Forces (ATF) to reinforce identified strengths and best practices and prioritize lower ranked outcomes for improvement plans. These groups subsequently led efforts to address lower rated results and document progress. Faculty perceptions will be remeasured through the SPS Faculty Engagement Survey scheduled to be deployed October 6, 2026.

SPS 2021 results showed greater than 70% of faculty respondents were satisfied or very satisfied with LSOM overall, and 81.4% agreed their role was clear. Satisfaction with collegiality and professional interactions was high at 84%; 82% felt their supervisor set a good example to reflect LSOM values; and 90% felt personally driven to help LSOM succeed. Only 11% of LSOM faculty did not feel LSOM fosters teaching excellence, which aligned with national benchmarks for this question. The SPS also demonstrated a low faculty turnover rate and a 1% burnout rate, though burnout symptoms were indicated by 24% of faculty which aligns with national benchmarks and may have been impacted by the COVID-19 pandemic.

Conclusions

OFF strengthens the LSOM learning environment by making faculty systems dependable, helping educators and leaders grow and develop, and directly supporting faculty well-being. Together, these supports allow faculty to create a healthier, more professional, and more supportive setting for LSOM learners.

LSOM Learning Environment Action Plan for AY2026-27

Based on the findings within and across the entities involved in this report, LSOM will focus on the following priorities during academic year 2026–2027:

1. **Preserve and reinforce supportive interpersonal culture.** Faculty, residents, staff, and student leaders should continue to receive recognition and development that reinforce respectful teaching, inclusive interactions, approachability, and appropriate professional role modeling. Existing strengths should be treated as institutional assets that require continued attention rather than as permanent conditions.
2. **Strengthen confidence in reporting and institutional follow-through regarding the learning environment.** LSOM students, residents, faculty, and staff should receive clear, repeated information about available reporting pathways, what occurs after a concern is submitted, how decisions are made, and the range of possible institutional responses. LSOM should provide periodic de-identified summaries of report categories, referrals, actions, and monitoring outcomes. These communications should explain why confidentiality may limit case-specific disclosure while demonstrating that concerns receive review and disposition.
3. **Evaluate learning environment and mistreatment reporting processes as additional data becomes available.** This may include examining the timeliness of review, consistency of documentation, completion of interventions, recurrence of similar concerns, and, when feasible, the experience of students who use the process.
4. **Continue focused monitoring of the clinical learning environment.** OUME, OGME, OFF, and clinical partners as appropriate should continue to review mistreatment reports and teaching evaluations for recurrence, clustering, and setting-level patterns. The absence of a confirmed repeat offender should not preclude monitoring of patterns involving services, teams, professional roles, or types of conduct.
5. **Monitor feedback from the LSOM class of 2028 cohort as it enters the clinical curriculum.** Compare subsequent Learning Climate Survey results with both its prior findings and those of the next MS2 class (class of 2029) to facilitate distinguishing a cohort-specific experience from a recurring phase-related pattern.

6. Correct programming for and improve participation in the 2027 OUME Learning Climate Survey. Core items should remain stable enough to permit comparison with the 2026 baseline. Future analysis should continue to triangulate with the GQ, subsequent ISA or institutional survey findings, course and clerkship evaluations, and mistreatment-reporting data.

7. Incorporate additional questions in the 2027 OGME Clinical Learning Environment Survey. Based on the ISA/LCS/CLE crosswalk, questions on resident awareness and clarity of mistreatment policies, as well as resident awareness of mistreatment prevention activities, will improve understanding of the learning environment.

8. Implement the SPS Faculty Engagement Survey in FY27, with a summary of strengths, i.e. high faculty satisfaction, and areas of lower satisfaction on which action plans will be based included in the 2027 LSOM Learning Environment Report.