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Editorial

Designing for Diversity: Integrating Universal Design for Learning in Medical Education

The last decade has rightly focused on opening the doors of medical education to students with disabilities—whether sensory, physical, or neurodevelopmental. Admission policies and regulatory frameworks have moved us from exclusion to access. But access, by itself, is not inclusion. What happens after admission—inside lecture halls, skills labs, wards, and examinations—determines whether these learners can participate with dignity and thrive. What is usually missed is the 'silent exclusion' which such students face, resulting in internalisation of the stigma in non-supportive environments, leading to feelings of lack of self-worth, depression and frustration. Such piled-up feelings manifest with either self-harm or aggression towards others.

In everyday teaching, many barriers remain invisible to those who are not sensitised to them. A deaf or hard-of-hearing student may follow slides but miss key nuances in a fast-paced discussion. A wheelchair user may navigate a college campus that is physically made accessible, but practically exhausting to navigate between postings. Neurodivergent learners may keep up intellectually but struggle with the speed, ambiguity, and social demands of clinical environments. None of this is intentional exclusion, yet the effect is the same: students are present, but not fully included.

For medical educators, the shift needed is both attitudinal and practical. We must move from a deficit lens—"what the student cannot do"—to a correctional one: "what conditions will allow this student to demonstrate competence?" It just implies giving such children a level playing field to perform to the best of their capabilities. This does not necessitate diluting standards, but rather refining them. Competence in medicine is about knowledge, clinical reasoning, communication, and professionalism—not about handwriting speed, hearing acuity without support, or the ability to stand for prolonged periods. The United Nations Convention on the Rights of People with Disabilities mandates their inclusion as a matter of right and not charity.

A powerful way to operationalise this shift is to embed Universal Design for Learning (UDL) into the curriculum. UDL is a proactive framework that anticipates learner variability and designs teaching accordingly, reducing the need for retrofitted accommodations. In practice, this means offering multiple means of representation (clear slides, pre-shared materials, captions or transcripts, visual summaries), multiple means of engagement (structured discussions, predictable routines, options for participation), and multiple means of expression (allowing knowledge to be demonstrated through written, oral, or practical formats where appropriate). When these options are built in from the outset, all learners benefit—not only those with identified disabilities. UDL can be easily aligned with the already implemented competency-based learning, wherein the entire curriculum is learner-based and learner-paced.

Alongside UDL, individualised supports remain essential. Captioning or sign-language interpretation for deaf students, accessible seating and pathways for those with mobility limitations, assistive technologies, flexible scheduling for health-related needs, and reasonable examination accommodations (such as extra time or alternative formats) are not concessions; they are enablers of fair assessment.

As medical colleges align with contemporary regulations supporting inclusion, the next step is to ensure that inclusion is lived in daily practice. Embedding UDL, refining assessment, and cultivating a humane, flexible teaching culture will move us from access to belonging. In doing so, we not only support individual learners; we enrich the profession with clinicians whose varied perspectives and strengths ultimately improve patient care.

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