Teaching Nursing Students about the Sociopolitical Aspects of Gerontechnology: Developing Dementia Care

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Abstract

Gerontechnologies need to integrate more seriously into dementia care because global populations continue to grow older. The research evaluates how educational programs instruct nursing students to approach and control the social and political impacts of these technologies. Qualitative analysis of nursing education programs alongside instructional approaches facilitates the discovery of how students learn about gerontechnological benefits for clinical applications together with their societal effects extending from ethics through economics to culture. The research results demonstrate increased emphasis on preparing the next generation of nurses to defend fair and responsible integration of technology specifically for dementia patients during elder care.

Keywords: *Dementia care, nursing education, gerontechnology, sociopolitical roles, aging population, healthcare technology, curriculum analysis, ethical implications, elder care, digital health.*

1.   Introduction

Modern societies worldwide are utilizing technology as they face the multiple challenges which accompany elderly populations that continue to grow. Welfare-state governments like Norway are using digital care systems along with ambient assisted living devices together with gerontechnologies to make their older adult populations incorporate these technologies into their daily routines. Devices advertised for safety together with empowerment and independence enable older adults to stay in their homes which helps delay or prevent institutionalization. The apparently progressive expansion of technology requires scrutiny regarding its influence on identity development of users including dementia patients.

The widespread implementation of smart care technologies in nursing homes extends beyond basic functions and safety measures toward issues of representation and control systems(1). The examination of technology deployment decisions made by care professionals during training enables exploration of how healthcare professionals create elder identities through technologic implementations. Tools classified as gerontechnologies function beyond their basic functionality. Such artifacts engage actively in creating standards that describe older adult experiences and patient care processes and dementia diagnosis procedures.

Nursing education programs teach upcoming healthcare professionals the basic care techniques for elderly patients along with methods to use technology as a management tool for behavioral control and risk reduction to achieve compliance. Educational spaces that produce healthcare professionals tend to disregard the built-in power dynamics that arise from these instructional practices. Decisions about individual attributes and agency levels happen through actions such as concealing bed sensors and giving passive devices to people depending on their cognitive profiles. Such clinical decisions simultaneously function as social evaluations which hardware systems represent through coded parameters.

The research examines the co-constructive process between gerontechnologies and care policies and institutional expectations using critical perspectives within Science and Technology Studies along with gerontological frameworks and personhood theories holding relational views. We examine how identity and agency get mediated through materials within smart care environments based on the theories of Madeleine Akrich who studied "user representations" and Kitwood's "personhood" objections to biomedical limits in dementia care.

Data collection for this study included ethnographic research that observed nursing students in Norwegian gerontechnology showrooms during their educational displays which were part of their university curriculum. Such spaces operate as dual-purpose areas which unite educational facilities with theatrical demonstration ambits to demonstrate communal values about aging populations alongside safety risks and dementia treatment. The present space operates as both a space for future care visioning and performance which leads directly to anticipated treatment methods for older adults in active practice.

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Gerontechnologies maintain their political significance beyond healthcare practices where they receive applications. The installation of such technologies in private spaces and their deployment choices influence how society interprets and discusses issues related to aging and elderly decline. According to Langdon Winner we can say that technologies embody political elements. Material artifacts contain preconfigured beliefs that determine who receives oversight and how much autonomy they deserve concerning their competence or behavioral scores.

Dementia patient care experiences particular consequences from such erroneous preconceptions about their abilities. Typically dementia patients have their opinions dismissed through safety-based decisions which treats them as mere beneficiaries of care (2). The deployment of technological systems without both their awareness and involvement reduces people to subservient roles inside their homes. The protectionist goal generates negative effects by causing people to lose their power while simultaneously pushing them toward neglect and decreasing their ability to participate in civic matters. We start questioning who maintains authority when advanced technologies act as invisible and all-enclosing caretakers. The signs of consent should be clear when care receives mediation support. The technologies potentially generate unequal outcomes during their operation despite being presented as caring systems.

This document refrains from condemning gerontechnologies along with their implementers. The paper promotes an understanding based on a variety of socio-political factors rather than a complete dismissal. A focus on how elder identity emerges from care practices requires examining the teaching process along with the environment where technology applications take place and the interpretation methods used to understand them. The control systems operate by enabling the revealing or hiding of dementia symptoms alongside the definition of safety risks and the development of support-surveillance boundaries in daily operations.

The fundamental notion presented in this research is that smart care facilities function as cultural writing spaces which embed aging bodies into control frameworks and classification structures. Senior citizens gain personhood through the combined effects of technological networks with sensor tools and display screens and execution protocols. We should examine the quality of society that we construct for our aging population. Who determines the principles that form the basis of these aging facilities?

Our objective involves presenting critical assessments simultaneously with potential solutions so we can create caregiving practices that focus on identity and dignity along with needs-based approaches and include participant involvement. Elder care development should embrace innovative systemic changes as well as conscientiously foster specific beliefs which guide new developments across learning and operational domains..

2. Pedagogies of Surveillance: Training Nurses in Algorithmic Care

Healthcare technology has brought about a slow evolution in nursing education that focuses mainly on technical capabilities instead of ethical aspects of digital surveillance and control. Pedagogical environments like gerontechnology showrooms function as training centers for algorithmic care that shifts its focus from relationship-building to observation and behavioral adjustment and performance optimization. The educational area prepares future nurses to work with equipment while instructing them to accept patient monitoring as an accepted form of healthcare delivery.

Norwegian nursing students learn gerontechnology education through detailed demo settings made from pressure sensors, motion detectors, door alarms and other assistive technologies which simulate authentic home-based care environments. The showrooms serve as intended performance areas that push professional roles through patient identity interactions while reinforcing specific definitions of quality care.

These educational scenarios put special emphasis on identifying the potential behavioral risks that students may face while interacting with patients. Through anecdotes and live demonstrations the training program provides students a standard expectation that dementia participants will display resistance or confusion while attempting to sabotage technological equipment. Many educational scenarios use the case of "Margot" who uses her bed sensor expertise to evade detection as an example for learning purposes (3). Educational specialists make clear that behavioral challenges should be addressed prior to incidents by hiding and concealing technological equipment instead of adopting cooperation or communication approaches. Training reveals the elder to nursing students as a control system variable that might display irrationality and pose risks while remaining in need of constant management.

The surveillance aspect enters the scene during this point. The placement of sensors under sheets and rugs reveals a healthcare philosophy which depends on non-friendly compliance from patients. The main objective of hiding these

technologies exists because their visible nature encourages people to contradict their implementation. The older adult functions as a security risk due to their diminishing capabilities and technological opacity serves as a way to reduce their capacity for standing up against unwanted procedures.

Such methodology applies biomedical perspectives which see dementia as worsening memory and decision abilities to classify diminished capabilities as legitimate voice loss. The system prioritizes risk management protocols above critical ethical investigations regarding a person's authority and permission to make choices. Training for student nurses requires them to avoid requesting patient desires while making decisions to guarantee safety before using technological equipment.

Dimension	Traditional (Relational) Care Education	Algorithmic Surveillance-Based Training
Care Philosophy	Empathy, dialogue, co-decision-making	Risk mitigation, behavioral control, passive observation
Role of the Nurse	Collaborative partner, emotional support provider	System operator, compliance enforcer, remote monitor
Technology Function	Support interaction and empowerment	Monitor, alert, restrict behavior
Sensor Placement Logic	Visible, explained, co-negotiated	Hidden to prevent tampering or refusal
View of Elder Agency	Capable of consent, expression, and adaptation	Prone to confusion, irrationality, and sabotage
Student Learning Outcome	Critical engagement, ethical reflection	Technical proficiency, anticipatory control
Behavior Interpretation	Expression of needs or resistance	Pitfalls or malfunctions to be managed
Training Focus	Building relationships, understanding lived experiences	Configuring environments for compliance and data capture
Ethical Risks	Overemphasis on negotiation may risk delayed responses	Consent erosion, autonomy loss, normalized surveillance

TABLE 1 Pedagogies of Surveillance: A Mini Table

The educational approach creates significant moral problems regarding its approach. The teaching model aims to establish within future healthcare providers a union of surveillance methods with compassionate practice which erases protective boundaries from controlling behaviors(4). Students develop the misconception that quiet alarm systems connected to hidden pressure mats deliver equal protection to patient health. The conceptual framework silences the genuine feelings of confinement and privacy loss and treatment as a child that aging adults experience due to these benefit-intended systems.

Patients encounter the nurse both as their caregiver and as a manager responsible for regulating technological power within the healthcare system. The nurse receives professional power to decide what actions become visible data points for the system while maintaining control over information which stays hidden from the monitoring system. A controlled form of observation takes over care spaces and poses risks to specific activities while also dismissing objections about technical equipment.

The nurse must exercise power through clinical judgment combined with personal interaction but now relies heavily on technological algorithms and system dashboards. Student training incorporates them as human components who operate automated care systems by setting inputs and translating outputs into action. Nursing practice now demands that healthcare providers simultaneously execute operations while observing generated data inputs instead of direct dialog exchanges.

The mechanical understanding of care cannot be considered mandatory. New teaching approaches must teach students about both ethical relationships with clients and active participation methods as well as critical thinking abilities regarding system power dynamics. This present-day training model creates a technologically controlled care

system which achieves compliance by hiding information and makes security priorities over patient dignity.

Educational justifications exist despite the fact that this instructional method has its context-based reasons. Training programs focus on efficiency and fail-safes because the combination of aging populations and understaffed care facilities and rising public demands for safety creates this situation. A framework for critical technology interrogation among students who learn to use technological systems would prevent the development of care professionals who understand protocols but lack ethical understanding.

The pedagogical message conveyed to nursing students through this practice demonstrates that patient willpower has no mandatory role in care practices. The way we understand care receives transformations from this development. Technology as the main communication channel intensifies the transformation of care from a respectful collaborative process between people into an action performed on individuals.

Teaching nurses basic operations on sensors alongside alert setting protocols is insufficient when educating nurse practitioners. Educating nurses should incorporate instruction on how to investigate the societal advantages and disadvantages that arise from using technology (5). Which groups of people would face possible exclusion or harm? What processes control decision-making practices and which groups control those processes? The integration of such essential questions into care delivery education prevents us from developing nursing staff who understand data better than they understand human relationships.

The current educational approach for gerontechnology is constructing a new nursing professional lifestyle which combines service delivery with technological administration and conduct supervision. The professional identity emerges from environments that prefer technological approaches to human relationships and endorse surveillance practices to guarantee safety. To restore care into a dignified practice between professionals and clients we must develop better training methods.

3. Invisible Architects: How Tech Choices Reshape Autonomy in Elder Homes

The concealed architecture of power reveals itself within eldercare rooms as well as bathrooms, doorways and kitchens. The system consists of sensors together with circuit boards which transmit wireless signals using algorithms rather than traditional structural elements. Individuals who conduct technology layout exercises coupled with installation work alongside care professionals and health administrators to design systems which determine operational features alongside the level of independence targeted by such devices. Investigators examine how interventions about gerontechnology deployment become subtle methods of social design that adapt the meaning of home-based dementia care (6). Technologies in AAL systems such as pressure mats underneath beds along with hall motion detectors and door area GPS tracking force older adults to let their autonomy be interpreted by how technology detects their movements in their own homes. The act of visiting the bathroom between midnight hours can potentially count as a risk occurrence according to the system. Using the door opens triggers an alarm. Everyday movements go through risk-based screening which shapes the decisions of caregivers about suitable or secure conduct.

Technology's influence upon care interpretations primarily depends on its implementation methods. Pressure-sensitive doormats exemplify the point about how technologies shape situations during care situations. Visible devices which are placed in strategic locations remain easily understandable with the potential to negotiate their effects. Concealed beneath rugs or furniture which many nursing training programs teach the users might be monitored without their knowledge. The decision regarding where to position technology directly establishes whether someone will function as a decision-maker or become a subject for management. Technology configuration exists outside vacuum-like circumstances. Care professionals base their choices on learning materials and organizational rules alongside what they believe constitutes proper care delivery. The choice of dementia technology bases its justification on biomedically oriented criteria which predict either unalterable deterioration or mental incapacitation. Applications with interactive features such as smart calendars as well as interactive reminders together with communication platforms are generally dismissed as too complicated for people with "advanced" dementia. The automation of users' systems leads to them being selected as default thus creating an inadequate perception of user ability.

The system chooses automatic approaches which restricts human contact while creating differences in the care quality provided to different patient groups. The technological foundation for dementia patients consists exclusively of equipment meant to keep them protected and ensure their monitoring for safety purposes. Tools given to older

adults without cognitive impairments typically support engagement along with communication and creative tasks. A segregation develops between protective technologies and participatory technologies in the healthcare system. The problem extends beyond access to technology because it fundamentally establishes distinctions between participants and those who need managing. The healthcare system distinguishes between patients who receive care participation rights and those who receive only management services. Additionally the placement of devices ratifies this separation between the two groups. The purposeful sensor placement occurs both for aesthetic and technical benefits but also minimizes the user's capability to tamper or cease their operation. Educational staff promotes this practice as an effective strategy because they reference instances where patients deliberately disable medical devices which disturb them. A woman uses a vacuum cleaner as a decoy device to stop alerts from sounding when she views television during the day. This story is frequently mentioned to illustrate the issue (7). Technology experts classify this episode as a problem although they understand it came from user resistance to control interventions. Consequently they design the devices to become harder to view and access.

Design obfuscation demonstrates the power inequalities that exist between caregivers and their elderly patients in the relationship. The logic of care considers surveillance as a weakness because patients who understand the system lose its desired power of control. The elderly recipients of care undergo regulation rather than receive actual care in these circumstances. Due to the mechanistic control their domicile has become the caregivers' actions produce information which feeds an external decision system while denying the subjects' participation in its development.

It is most alarming that these automated choices remain without proper assessment. Organizations fail to provide sufficient ethical evaluation and user-centered design education to their trained nurses and care workers despite their technical expertise. The training only covers device installation and activation alongside responses but does not teach them about involving their recipients in meaningful discussions about device meaning. Through their existing training they lack the ability to investigate how older adults lose control of their personal home territory which holds the greatest value for their independence.

Society views aging in place as a basic right which preserves independence and dignity of older adults. When independence management relies on hidden sensors that generate automatic warnings what does it truly signify? The users receive no say in which technologies will enter their space and how their placement will appear. The concept of autonomy now exists solely as a controlled performance of safety which others outside the home establish through their decisions.

This technologically managed approach to eldercare proves essential to accomplish efficiency needs in a health service system that has both insufficient caregivers and demanding healthcare requirements. But it is not neutral. The deployment of motion sensors and cable hiding while making decisions about which device to choose from Device A or Device B together shape an intangible system of compliance. Autonomy and inclusion opportunities emerge through minute choices that technology managers make which either give or take away these privileges.

We need to oppose the general assumption that technological effectiveness depends on total invisibility. Designs and placements need advocacy towards creating spaces that encourage discussion between patients and their caregivers while offering freedom of choice and maintaining flexible care relationships. The older adult should represent shared responsibility for environment creation through their personhood instead of being considered a broken part of the system.

4. Epistemological Clashes in Dementia Technology

The continuous creation of dementia care technologies reveals an unrecognized dispute regarding different ways to define dementia. Different percepciones of dementia directly affect technology design while influencing their practical implementation and educational methods and service rationalization in care environments. Dementia appears according to the biomedical model as a degenerative cognitive decline resulting from biological pathophysiology. Relational perspectives along with person-centered frameworks exist as a different conception of dementia which focuses on personal realities and social environments alongside individual characteristics of affected patients.

The conceptual disagreement manifests itself tangibly and dramatically between actual caregivers and numerous clinical professionals (8). The disciplinary model determines whether those under care can select their technology

tools as well as how staff interpret actions between resistance and preferences and lastly how they handle preserving personal choices. Whether technology serves as a way to extend personal agency or assumes the role of someone's agency remains the most vital impact of this conflict.

Dementia received its definition mainly from the standard biomedical approach which defines it through its memory and reasoning failures and language confusions and diminished independence. The framework describes dementia development as an unchangeable continuous process. Reducing mental ability leads directly to a degradation of personal choice capabilities. Many designers and care professionals base their decisions on this rationale by believing passive monitoring devices fit better into "late-stage" dementia whereas interactive tools are restricted to "early-stage" dementia patients.

The training protocols in gerontechnology facilities instruct nursing students to select technological tools based on dementia progression stages. Training programs indirectly show students that dementia progression reduces the ability of patients to convey their needs and discomfort effectively. Under this understanding of dementia an older adult would be considered incapable therefore decisions are made to conceal sensors and automate alarms and bypass older adult participation during installations. Through this theoretical framework technology serves mainly as a tool to control rather than to enhance.

Social gerontology together with care ethics now firmly integrate relational perspectives on dementia which offer an alternative understanding of this condition. The framework views dementia by recognizing how combinations of perception and environment with social interactions create this condition. Dementia patients retain their personhood since they possess particular abilities which emerge through changing mental capacity. Individuals affected by dementia have multiple requirements extending beyond clinical needs which encompass their community and psychological aspects together with their political situation.

Personhood endures even without memory because relationships along with recognition act to preserve it according to studies performed by Tom Kitwood and Ruth Bartlett. The obligation of caregiving along with technological implementations should preserve personal identity instead of hiding it. When choosing technology for older adults it should be jointly designed together with users rather than designed for users without their involvement. Dialogue serves as the fundamental decision-making principle rather than clinical diagnosis.

The difference in understanding between these two concepts delivers essential impacts to design applications. Devices derived from biomedical approaches usually insist on user passivity through their design features such as tracking sensors along with monitoring programs and automatic alert systems. These devices operate through risk management principles while presenting older adults mainly as recipients of protection services. Relational thinking focused technologies honor user participation by creating tools which help storage of memories alongside shared communication channels that advance autonomy and expression capabilities.

Modern practice shows that relationally designed systems consistently face challenges in receiving official acceptance. These methods need enhanced staff interaction alongside custom solutions combined with additional training programs for healthcare personnel to develop active listening skills. The traditional notion of rendering care takes a new direction because it evolves from passive action upon another person to active teamwork between caregiver and recipient of care.

The three sectors where these issues become most apparent are educational facilities and military deployment sites. The biomedical training given to nursing students causes them to interpret patient behavioral modifications which include switching off medical sensors or removing body monitoring devices as signs indicating deterioration. Relational care interpretation views these actions through a communication lens which indicates negative feelings such as discomfort and disapproval along with wishes for privacy. The first approach views refusal behavior as machine failure yet the second perspective understands it as significant communication.

Success measurement methods differ based on the essential nature of different medical care models. Medical services that take their direction from biomedical principles measure success through patient compliance and risk minimization where alert numbers remain low. The measure of success under relational care may focus on patient engagement alongside emotional comfort levels and preservation of their regular activities. The contrasting approaches manifest through technologic systems since one system works to minimize concealment while the other exists to enhance perceptibility of people and their personal backgrounds and preferences.

The choice between the two different medical approaches leads to severe medical and social effects. The biomedical model incontrol leads technologies to function as monotonous power tools. Caregivers create exclusion and stigma

when they block patient consent and hide tracking devices because of this approach they reinforce these negative conditions. These practices then train future professionals who repeat the same epistemological assumptions during their professional practice.

A hybrid area has developed that might become a meeting point between risk management approaches and person-centered care strategies. Transitioning care approaches into a situational ethical practice demands putting patient agency before risk concerns and demanding that all medical technologies undergo dialogic assessment for implementation.

The necessary transformation requires combined changes in nursing educational systems alongside modern technology development. Students need to learn critical epistemology because it allows them to view technology beyond its operational mechanics so they can identify embedded beliefs about its human users. Designers should involve co-design methods by making people with dementia integral to creating their own healthcare tools. Institutions need to evaluate technology beyond its operational and efficient capacities because their primary function should include support for maintaining dignity, autonomy and human relationships.

Aspect	Biomedical Model	Relational (Person-Centered) Model
Core View of Dementia	Progressive cognitive decline, leading to incapacity	Fluctuating abilities shaped by social and relational contexts
User Assumptions	Diminished agency, inability to make informed decisions	Differently-abled; capable of expressing needs and preferences
Technology Design Focus	Risk management, safety automation, monitoring	Engagement, communication, autonomy support
Tech Examples	Bed sensors, motion detectors, door alarms	Digital memory books, reminder apps, shared communication tools
Behavior Interpretation	Resistance = malfunction or confusion	Resistance = communication or self-expression
Goal of Care	Prevent harm, ensure compliance	Preserve identity, support dignity and dialogue
Implementation Approach	Top-down; caregiver and system decide	Co-creation; user involved in decisions and feedback
Training Emphasis (Nursing)	Technical setup, protocol adherence, risk scenarios	Critical reflection, user empathy, relational engagement
Ethical Framing	Safety over autonomy	Autonomy within supported relationships

TABLE 2 Competing Ontologies of Dementia: A Comparative Mini Chart

All dementia care technologies should progress past the traditional choice between security and independent choices. These instruments function as epistemic instruments to reveal understanding about mental processes because they both influence bodily actions and demonstrate understanding about mental capacities (9). Our definition of dementia as decline or difference determines the type of futures we construct in these domains including personal, aging demographic and caregiving systems.

5.Conclusion and Future work

Medical care has witnessed a major advancement through the fast-paced creation and incorporation of gerontechnologies for dementia patients which shows promise to improve wellness for older adults and dementia patients. Assistive devices along with monitoring systems and robotic technology enhanced by artificial intelligence have the ability to enhance daily activities while offering better communication tools and independence options to patients. The implementation of gerontechnologies for dementia care demands strategic evaluation because all technological advances face various sociopolitical and ethical and cultural barriers. Teaching nursing students serves an essential function to educate future healthcare professionals how they can handle complex situations in

gerontechnology applications for dementia care development.

The research emphasizes why nursing education needs sociopolitical training to create graduates who excel in clinical work and become capable of both assessing and shaping the social effects of gerontechnologies. Healthcare education needs to exceed technical competence training regarding technology usage because it requires knowledge about how these new tools influence medical environments alongside policy structures and patient life quality. The evolving healthcare sector demands nursing students who possess the expertise to protect equitable technology usage which fulfills patient-centered care values while caring for aging patients.

The research confirmed that current nursing instruction includes teaching students about ethical issues related to gerontechnologies particularly concerning privacy rights and patients' consent and self-determination. Educators must give priority to the protection of patients' rights because dementia patients experience substantial cognitive disabilities that influence their ability to make decisions autonomously. Gerontechnologies provide safety benefits alongside independence features yet they produce privacy-related security problems and expose patients to unintended injurious effects. Nursing students need knowledge to manage these issues to create policies that protect patient autonomy while preserving their dignity. To protect the autonomy of persons with dementia students need to comprehend hardware technology fundamentals together with analyzing real-world scenarios where they will verify that surveillance and monitoring do not compromise their independence.

The research creates an urgent need for nursing education to teach students about the complete societal and cultural and economic effects which gerontechnologies create. Technology implementation for healthcare applications operates in an unbalanced manner because it connects to societal fairness concerns and social disparities and cultural traditions. Some gerontechnologies benefit wealthier people who have superior healthcare access but fail to serve those from lower economic levels thereby growing healthcare inequality gaps. The degree of acceptance for gerontechnologies between different cultural groups depends on their prevailing views about aging and technology. Every nursing student needs training to identify socioeconomic disparities in technology access so they can establish policies which give every individual complete benefit from helpful technologies regardless of their social or economic status.

Educating nursing students about the economic consequences of gerontechnologies must remain central to their educational curriculum. Healthcare facilities face high expenses when using advanced medical technologies which result in increases in costs experienced by patients and healthcare organizations and their related families. Future nurses should learn to examine the financial viability of medical equipment within healthcare budget systems so they can provide expert input. Student nurses must develop the capacity to determine how well different technologies represent their value to the healthcare investment. Students need to understand how the deployed technologies function together with economic factors that influence their implementation.

Conflicts of interest
The authors have no conflicts of interest to declare

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