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Spatial Negotiation between Patients and Caregivers in Outpatient Administrative Settings: A Design Anthropology Perspective in Regional General Hospital dr. Iskak

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ABSTRACT

In the realm of healthcare facilities, accessibility is commonly perceived as a physical and technical condition, often evaluated through spatial standards and design compliance. However, such an approach tends to overlook the intricate nature of real user interactions within healthcare settings. This study endeavors to investigate accessibility as a relational and experiential process, specifically focusing on the interaction between patients, caregivers, and space within the outpatient installation of Regional General Hospital dr. Iskak. Employing a qualitative approach within a design anthropology perspective, this research utilizes limited participatory observation, visual documentation, and field notes to gather data from patients with mobility impairments and their caregivers. The analysis employs a thick description approach to interpret behavioral patterns, spatial negotiation, and user experiences in actual use settings. The findings reveal that accessibility is not an isolated individual condition but is constructed through the relational interaction between patients and caregivers. Spatial use is characterized by distributed activities, role negotiation, and adaptive behaviors in response to spatial constraints. Users actively appropriate space and reorganize spatial use to maintain comfort and coordination, indicating that accessibility emerges through everyday practices and embodied interaction. This study underscores the limitations of conventional universal design approaches, which primarily concentrate on individual users and physical standards. It proposes a shift toward contextual, interaction-based, and experience-oriented design frameworks that more accurately reflect real-use conditions. These findings contribute to expanding the comprehension of accessibility as a dynamic and relational phenomenon within healthcare environments.

KEYWORDS

Spatial Interaction, Partients, Caregivers, Negotiations, Accessibility

INTRODUCTION

Hospital buildings are public facilities designed to accommodate diverse user needs, particularly those of patients with varying physical conditions and health limitations. In healthcare contexts, accessibility is commonly understood as the ability of users to reach and utilize facilities safely and independently, often assessed through physical and technical parameters such as spatial dimensions, facility provisions, and compliance with universal design standards (Ulrich et al., 2008); (Hamraie, 2017). However, such an understanding tends to frame accessibility as a measurable design problem, positioning users as individuals who interact directly and independently with space (Tanzillah & Sakya, 2024).

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In practice, spatial experience in healthcare environments is rarely individual. Patients are frequently accompanied by caregivers who assist mobility, facilitate communication, and support decision making processes during service interactions (Mizumoto et al., 2025); (WHO, 2022). This relational condition becomes more evident in Outpatient Installations (*Instalasi Rawat Jalan*), where service processes including registration, consultation, and medication retrieval occur in continuous sequences, generating high user density and complex interaction patterns . In such conditions, accessibility is not only determined by physical provision, but also by how users interact, adapt, and coordinate within spatial constraints. Physical environmental elements significantly influence users' comfort and experience, highlighting the role of spatial design in shaping service encounters (Syakira & Saphiranti, 2025).

Previous studies on hospital accessibility have predominantly focused on structural and technical aspects, such as circulation efficiency, facility standards, and universal design implementation (Heylighen et al., 2017); (Imrie, 2012). More recent studies have incorporated patient experience and service quality into accessibility discussions. However, these approaches largely rely on quantitative models and system level analysis, limiting their ability to capture real spatial interactions. Furthermore, recent research highlights that patient-caregiver interactions remain insufficiently addressed in hospital design studies, despite being fundamental to actual healthcare practices (Marini et al., 2025). While caregivers are widely recognized in clinical and decision making contexts, their role in shaping spatial interaction and accessibility within healthcare environments is still underexplored (Marini et al., 2025).

This limitation becomes particularly evident in micro scale service spaces such as administrative counter areas, where queuing, communication, and movement occur simultaneously within spatial constraints. At dr. Iskak Regional General Hospital or in Indonesian called Regional General Hospital dr. Iskak, Tulungagung, which a regional referral hospital with high patient volume, these conditions reveal how patients and caregivers continuously negotiate positions, roles, and interactions in real situations .

Therefore, this study adopts a design anthropology approach within an interpretative framework to examine accessibility as a relational and experiential process. Rather than viewing accessibility as a static outcome of design, this study conceptualizes it as a dynamic process shaped by embodied interaction and everyday spatial practices (Pink et al., 2020); (Boys, 2014).

Based on this perspective, this research aims to analyze the process of spatial negotiation between patients and caregivers at the administrative counter area of the Outpatient Installation in Regional General Hospital dr. Iskak, Tulungagung. Specifically, the study focuses on interaction patterns, role distribution, and adaptive spatial strategies that emerge in real-use situations. The novelty of this research lies in its emphasis on accessibility as a relational and experiential process, rather than solely as a physical or technical condition.

METHOD

This study employs a qualitative approach with a design anthropology perspective to understand the interaction between patients and caregivers in accessing space within the administrative counter area of the Outpatient Installation. This approach is chosen to explore behavioral dynamics, spatial experiences, and forms of negotiation that emerge during the use of healthcare facilities. In this context, space is not perceived as a static entity, but as a product of social practices and user interactions (Agustina & Saragi, 2018a). Contextual interior design highlights how spatial arrangements can be intentionally structured to influence user interaction, comfort, and overall experience within a particular environment (Zukhrufa et al., 2024).

This research is an extension of a previous study that applied a quantitative descriptive method to measure the level of accessibility in hospital buildings (Ayu & Sakya, 2021). In contrast, the present study focuses on an in depth exploration of user experience through behavioral observation in real-use settings.

The study was conducted in the administrative counter area, waiting area, and circulation corridors of the Outpatient Installation at Regional General Hospital dr. Iskak. These locations were selected due to their high intensity of user interaction and the complexity of service activities. The

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research subjects consisted of patients with locomotor impairments who use mobility aids, such as canes, crutches, walkers, and wheelchairs, as well as their accompanying caregivers. The subjects were selected using purposive sampling based on user characteristics relevant to the study's focus on interaction and accessibility.

Data were collected through limited participatory observation, visual documentation, and floor plan. Observations were conducted directly without intervening in user activities, focusing on movement patterns, interactions during queuing and service processes, and the use of spatial elements such as service counters, seating, and circulation paths. Visual documentation, including photographs and spatial layouts, was used to capture spatial configurations, body positions, and physical constraints encountered during spatial use. Field notes were employed to record specific events, including access barriers, user adaptation strategies, and forms of spatial negotiation between patients and caregivers. Kholilah et al. (2019) highlight that spatial understanding extends beyond physical form, encompassing cultural meanings and human interactions that shape how space is experienced.

Data analysis was conducted using a descriptive qualitative method with a thick description approach (Geertz, 2008), aiming to interpret the meaning behind user actions and interactions. The analysis process included identifying interaction patterns between patients and caregivers, examining forms of spatial negotiation such as positional adjustments and movement coordination, and interpreting the relationship between user behavior and spatial configuration. The analysis was conducted iteratively by linking empirical findings with accessibility concepts and universal design principles to understand the alignment between spatial design and user needs in context.

RESULT AND DISCUSSION

1. Spatial Context and Patterns of User Acitivity

The Outpatient Installation at Regional General Hospital dr. Iskak, Tulungagung, demonstrates a high intensity of activity, particularly at primary service points such as the administrative counter, waiting area, and circulation corridors. These spaces form an interconnected sequence of service environments, through which patients and caregivers move in a continuous flow during the healthcare process. High user density creates a dynamic and overlapping spatial condition, where movement patterns are no longer linear or individual. Instead, users navigate the space through constant adjustment and interaction with others. This condition aligns with previous findings that hospital environments often involve complex user interactions that influence both service efficiency and user experience.

The following is the floor plan of the Integrated Polyclinic Building, 1st Floor, Regional General Hospital dr. Iskak, Tulungagung.

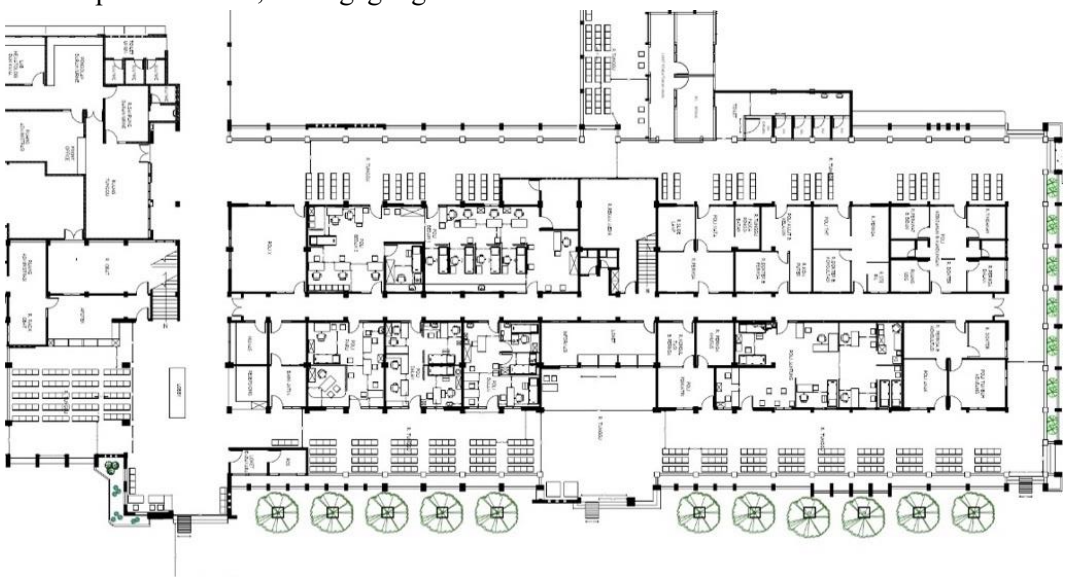

Figure 1. Floor Plan of the Integrated Outpatient Clinic Building, 1st Floor, Regional General Hospital dr. Iskak (Head of the Non-Medical Support Services Division, Regional General Hospital dr. Iskak, 2020)

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As a shared public space, the Outpatient Installation facilitates the emergence of simultaneous and often unintentional social interactions within functional service areas. These interactions are not limited to patient–caregiver relationships, but also occur among patients and between caregivers, forming a broader network of spatial and social engagement within the environment.

2. Patient and Caregiver Interaction in Service Processes

Observations indicate that patients with locomotor impairments are almost always accompanied by caregivers when accessing healthcare services. Caregivers do not merely function as passive supporters, but actively participate in the service process, particularly in facilitating mobility and communication (Hasanah & Grahita, 2024).

Figure 2. Patient and Caregiver Interaction
Source: (Candradewi, 2021)

This finding is consistent with reports from the World Health Organization, which highlight that individuals with physical impairments often exhibit a high level of dependency on caregivers for accessing healthcare services and performing daily activities (WHO, 2022). Similarly, previous studies have demonstrated that caregivers play a crucial role in facilitating healthcare access, especially for elderly patients and those with mobility limitations (Mizumoto et al., 2025). Furthermore, caregiver involvement has been recognized as a key component of patient centered care, emphasizing collaborative engagement between patients, families, and healthcare providers in the care process (Epstein & Street Jr, 2007).

Within the spatial context, this interaction forms a collaborative system between patients and caregivers. Caregivers tend to assume a more active role in spatial navigation and communication with healthcare staff, while patients adjust their body position and follow directional guidance. This pattern indicates that accessibility is not solely an individual capability, but is constructed through coordinated interaction between two users in real-use situations.

3. Forms of Spatial Negotiation in the Administrative Counter Area

Observations indicate that the administrative counter area is not the space with the highest intensity of spatial negotiation. Spatially, this area has relatively sufficient capacity and is divided into two service types, there are BPJS counters located at the front with standing service units, and general counters at the rear with seating facilities.

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Table 1. Forms of Spatial

No.	Space : Administrative Counter Area	Negotiation
1.	 BPJS Counter & Waiting Room	At the BPJS counters, eight service booths are available, and queue formation does not appear as a continuous linear line. Instead, several patients are observed waiting in the outpatient waiting area.
2.	 Public Counter & Waiting Room	A similar pattern occurs in the general counter area, where queues are not prominently visible. Caregivers tend to remain near the counters, while patients wait in adjacent waiting areas.

This condition indicates a redistribution of waiting activities to surrounding spaces, which reduces spatial congestion at the counter area. As a result, spatial negotiation still occurs, but in a dispersed rather than centralized manner. The identified forms of spatial negotiation include:

Table 2. Forms of Spatial Negotiation

Positional negotiation	Distance negotiation	Role negotiation
where caregivers take the front position to interact with administrative staff, while patients remain in nearby waiting areas.	where patients deliberately avoid the counter area to reduce physical congestion, prevent collisions with other users, and secure seating availability. This behavior reflects a form of spatial competition in accessing limited seating resources	where caregivers act as intermediaries in communication between patients and administrative staff.

This phenomenon demonstrates that patient and caregiver interaction is not only social but also spatial in nature. Previous studies have highlighted that such interactions are often overlooked in healthcare spatial design, despite their significant impact on user experience (Marini et al., 2025); (Cordeaux et al., 2025).

Furthermore, these findings suggest that spatial configuration indirectly shapes interaction patterns and role distribution within healthcare service systems. Prior research has shown that the design of healthcare environments influences user behavior, including communication patterns, mobility, and family involvement in care processes (Ulrich et al., 2008) (Hussein & Abubakar, 2025).

4. Behavioral Adaptation to Spatial Constraints

Observations indicate that users exhibit various forms of behavioral adaptation in response to spatial constraints, occurring spontaneously and situationally. These adaptations are not random; rather, they reflect responses to spatial configuration, user density, and individual needs in accessing healthcare services. Such patterns align with studies showing that user behavior in healthcare environments is shaped by the interaction between spatial layout, activity flow, and environmental pressures (Dalton et al., 2012). Interior design development should be guided by conceptual approaches that respond to user needs and the specific context of the environment (Yusuff et al., 2024).

Differences in service space typologies influence the forms of adaptation observed. In the BPJS counter area, which operates with a standing service system and lacks a designated waiting area, patients are typically positioned in more comfortable locations, such as outpatient waiting areas or peripheral zones. This strategy reduces interference with circulation flows and minimizes exposure to congestion. Meanwhile, caregivers proceed directly to the counter to complete administrative

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processes, while maintaining intermittent visual coordination with patients. This reflects a form of distributed interaction, where activities are spatially separated but remain functionally connected (Dalton et al., 2012).

In contrast, the general counter area, which provides seating and a waiting space, demonstrates variations in behavior based on patient condition. Patients who are able to walk independently tend to remain near the counter area, whereas patients with limited mobility, such as wheelchair or stretcher users, prefer waiting in outpatient waiting areas that are perceived as safer and more accommodating.

Beyond formal service pathways, users also engage in informal spatial practices. Since administrative procedures are often handled by caregivers, patients do not always follow the prescribed service flow. This leads to a redistribution of waiting activities to outpatient waiting areas, which consequently become zones of intensified spatial negotiation due to increased density. In such situations, users continuously adjust their positions and interpersonal distances.

Another significant phenomenon is the appropriation of circulation corridors. Corridors, originally intended for movement, are partially transformed into informal waiting areas, resting spaces, or temporary parking zones for wheelchairs and stretchers. This reflects a process of spatial appropriation, in which users reinterpret and modify spatial functions to meet unmet needs (Lefebvre, 1991).

In addition to physical adaptation, non-verbal communication occurs between patients and caregivers, both at close and distant ranges. These interactions play a crucial role in maintaining coordination despite spatial separation. Overall, these findings demonstrate that users do not passively follow spatial design, but actively negotiate and reshape spatial use. This supports the concept of embodied interaction, which emphasizes that spatial experience emerges through the interaction between bodies, objects, and environments (Pink et al., 2020).The following table explains the forms of user behavioral adaptation to spatial constraints:

Table 3. Forms of User Behavioral Adaptation to Spatial Constraints

No.	Adaptation Aspect	BPJS Counter (Standing Type)	General Counter (Seated Type)	Outpatient Waiting Area & Corridor
1.	**User Positioning**	Patients positioned in outpatient waiting area or peripheral zones	Independent patients wait near the counter; Mobility impaired patients remain in outpatient areas	Users dispersed and continuously adjust positions
2.	**Caregiver Role**	Active at the counter; Patient remains in separate area	Caregiver interacts with staff; Patient waits nearby	Caregiver moves between patient and service points
3.	**Use of Space**	No waiting area; Activities distributed to other spaces	Waiting area used according to capacity	Corridors appropriated for seating, resting, and patient with mobility aid waiting
4.	**Distance Negotiation**	Avoidance of congestion at counter	Relatively stable interaction distance	High; Frequent adjustments due to density
5.	**Behavioral Adaptation**	Waiting in alternative spaces	Adjustment based on physical condition	Continuous repositioning and movement adaptation
6.	**Interaction Type**	Visual coordination (long-distance)	Direct and visual interaction	Predominantly non-verbal interaction

The table illustrates that behavioral adaptation is influenced not only by individual conditions but also by spatial configuration and the distribution of activities within the service system. Differences in counter typology produce distinct adaptation patterns, while spatial density drives the redistribution of activities into adjacent areas.

These findings suggest that users actively appropriate space and develop alternative spatial strategies beyond the intended design. This aligns with studies indicating that spatial behavior is

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shaped by adaptive responses to environmental constraints and opportunities (Dalton et al., 2012). Siburian et al. (2020) suggest that design analysis can serve as an evaluative framework for understanding how spatial or visual arrangements shape user interpretation and interaction. Furthermore, the findings reinforce the notion that accessibility should be understood as an experiential and relational process, rather than merely a technical provision.

5. The Relationship between Spatial Configuration and Accessbility Experience

To examine how spatial configuration influences accessibility, observations were conducted in the administrative service areas of the outpatient installation. The comparison between the BPJS and general registration counters reveals differences in service organization, waiting arrangements, and user positioning, as presented in Table 4.

Table 4. Characteristics of Administrative Counter Areas

Aspect	BPJS Counter (Standing Type)	General Counter (Seated Type)
Service Type	Standing	Seated
Number of Counters	±8 booths	Several booths
Waiting Area	Not available	Available
Queue Pattern	Dispersed, non-linear	No visible queue
User Role	Caregiver dominant	Caregiver dominant
Patient Position	Outpatient waiting area	Counter / outpatient area

The BPJS registration area consists of approximately eight standing counters without a designated waiting area, resulting in dispersed and non-linear queue patterns. In contrast, the general registration counter provides seated services and a waiting area, although caregivers remain the primary actors interacting with administrative staff. Across both service types, patients with mobility impairments are generally positioned away from the counter while caregivers complete administrative procedures. These findings indicate that the organization of administrative space influences how healthcare services are accessed, particularly for users with limited mobility.

To further understand users' spatial adaptation, observations of waiting areas and circulation spaces were conducted. The results are summarized in Table 5.

Table 5. Patterns of Waiting Area and Surrounding Space Usage

Aspect	Counter Waiting Area	Outpatient Waiting Area	Corridor
Intended Function	Administrative waiting	Clinical waiting	Circulation
Actual Use	Caregivers waiting	Patients waiting	Seating / mobility aid parking
Negotiation Intensity	Low	High	High
Density	Moderate	High	High
Adaptation Level	Limited	High	Very high

The observations reveal a discrepancy between the intended and actual use of space. Administrative waiting areas are predominantly occupied by caregivers, whereas patients prefer outpatient waiting areas that provide greater comfort and security. Corridors are frequently appropriated as temporary waiting spaces and parking areas for mobility aids. The high levels of spatial negotiation and behavioural adaptation indicate that users continuously reorganize available spaces to accommodate their physical conditions and healthcare needs.

These findings demonstrate that accessibility is shaped not only by the provision of physical facilities but also by the interaction between spatial configuration and user practices. Spatial characteristics, including counter height, circulation width, and spatial density, directly influence users' ability to access healthcare services independently. Similar observations have been reported by Zahra and Mansoor (2024), who argue that design decisions influence both functional accessibility and users' emotional experiences. Likewise, Ayu and Sakya (2021) emphasize that

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limited circulation space and inadequate accessibility features reduce the quality of healthcare services for users with mobility impairments.

From an environment–behavior perspective, spatial organization influences movement patterns, social interaction, and behavioural responses (Gifford et al., 2011). In the present study, spatial limitations encourage adaptive strategies in which caregivers assume responsibility for navigation and administrative communication while patients remain in locations perceived as safer and more comfortable. Rather than representing individual dependence alone, this behavioural adaptation illustrates how users negotiate spatial constraints to maintain effective access to healthcare services.

These findings also reinforce patient-centered and family-centered care approaches, which recognize caregivers as integral participants in healthcare delivery (Ulrich et al., 2008; Frampton et al., 2017). Hasanah et al. (2024) further argue that healthcare environments should be designed according to the characteristics and needs of diverse users. Extending these perspectives, the present study demonstrates that caregiver involvement is not only a source of emotional support but also a practical response to spatial constraints within administrative service areas. Therefore, accessibility should be understood as a relational outcome emerging from the interaction between spatial design, user behaviour, and caregiver participation rather than solely as compliance with technical accessibility standards.

6. Accessibility as a Relational and Experiential Process

The findings demonstrate that accessibility in the outpatient installation of Regional dr. Iskak extends beyond compliance with physical accessibility standards. Instead, accessibility emerges through continuous interactions among spatial configuration, user behaviour, and caregiver participation. This synthesis is presented in Table 6.

Table 6. Synthesis of Accessibility as a Relational and Experiential Process

Dimension	Key Findings	Observational Evidence	Implications for Accessibility	Design Implications
Spatial Configuration	Service spaces are interconnected and dense	Counters, waiting areas, and corridors overlap	Access is non-linear	Flexible circulation design
User Interaction	Patients are not independent, always accompanied	Caregivers dominate at counters	Access is relational	Design for multi-user interaction
Spatial Negotiation	Redistribution of activities occurs	Patients wait in alternative spaces	Access occurs across spaces	Spatial integration needed
Behavioral Adaptation	Users adjust spatial use	Corridors used for seating/parking aids	Access is dynamic	Adaptive and flexible design
User Experience	Comfort determines spatial choice	Patients prefer safer waiting areas	Access is experiential	Experience-based design
Caregiver Role	Caregivers act as mediators	Administrative interaction handled by caregivers	Access is not individual	Facilitate patient–caregiver interaction

Table 6 illustrates that accessibility is produced through interconnected spatial, behavioural, and social processes. Dense spatial layouts, overlapping functions between waiting areas and circulation spaces, and the redistribution of user activities create dynamic patterns of space utilization. Rather than following predetermined spatial arrangements, patients and caregivers continuously adapt their positions and movements to achieve effective access to healthcare services. These findings indicate that accessibility is not a fixed physical condition but a dynamic process shaped by everyday interactions within healthcare environments.

A significant finding is the emergence of the patient–caregiver relationship as the primary unit of healthcare access. Patients with mobility impairments generally remain in locations perceived as safer and more comfortable, whereas caregivers undertake administrative communication and spatial navigation. This coordinated division of roles forms a functional dyadic unit, consistent with the collaborative healthcare model proposed by Berg and Upchurch (2007). The findings also support

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patient-centered and family-centered care principles, which emphasize caregiver participation as an essential component of healthcare quality (Ulrich et al., 2008; Frampton et al., 2017). However, the present study extends these perspectives by demonstrating that caregiver involvement is driven not only by psychosocial support but also by the spatial limitations of healthcare facilities.

Users also actively negotiate available spaces to maintain comfort, reduce physical effort, and facilitate coordination during healthcare services. The use of corridors as temporary waiting spaces and parking areas for mobility aids, together with patients' preference for alternative waiting areas, reflects the experiential nature of accessibility. This observation is consistent with Pink et al. (2020), who argue that spatial experience is constructed through embodied everyday practices. Accordingly, accessibility should be evaluated not only by the presence of accessible facilities but also by how users experience, interpret, and adapt to the built environment.

To examine the broader implications of these findings, they were compared with the principles of Universal Design, as summarized in Table 7.

Table 7. Relationship between Findings and Universal Design Principles

Universal Design Principle	Relevance in Findings	Identified Limitations	Required Development
Equitable Use	Access for all users	Does not consider relational users	Relational-based design
Flexibility in Use	Multiple ways of using space	Focused on individuals	Multi-user flexibility
Low Physical Effort	Supports physical ease	Insufficient for assisted users	Integration of caregiver roles
Tolerance for Error	Reduces risk	Users still need to adapt	Adaptive design approach
Size and Space	Adequate for individuals	Not sufficient for two users	Interaction-based spatial dimension
Perceptible Information	Clear information delivery	Does not ensure accessibility experience	Integration of spatial experience

The comparison demonstrates that Universal Design remains an important framework for promoting inclusive environments; however, it primarily emphasizes individual users and does not fully capture the relational nature of healthcare accessibility. Similar concerns have been raised by Agustina and Saragi (2018b), who note that physical compliance alone cannot fully represent users' accessibility experiences. Furthermore, Falahi and Larasati (2024) emphasize that design evaluation should extend beyond assessing physical artifacts to include users' actual interactions with space. Consistent with these perspectives, the present study indicates that accessibility is shaped through coordinated interactions between patients, caregivers, and spatial configurations. Consequently, healthcare design should move beyond conventional compliance-based approaches toward interaction-oriented and context-sensitive design strategies that better accommodate relational patterns of healthcare access.

CONCLUSION

This study demonstrates that accessibility in the outpatient installation of Regional General Hospital dr. Iskak should not be understood solely as compliance with physical accessibility standards. Instead, accessibility emerges as a relational and experiential process shaped by the interaction between spatial configuration, user behaviour, and caregiver participation. Patients with mobility limitations rarely access healthcare services independently but function as part of a patient–caregiver unit in which caregivers undertake navigation and administrative communication while patients remain in spaces perceived as safer and more comfortable. The redistribution of activities across waiting areas, circulation spaces, and service counters further indicates that accessibility is achieved through coordinated interaction and continuous behavioural adaptation rather than through a linear service process.

This study contributes to healthcare accessibility research by conceptualizing relational accessibility as a complementary perspective to conventional Universal Design approaches. While Universal Design remains essential for promoting inclusive environments, the findings demonstrate that physical compliance alone cannot fully address the complexity of healthcare settings, where accessibility depends on coordinated interactions among patients, caregivers, and spatial configurations. Therefore, future healthcare design should adopt more context-sensitive, interaction-oriented, and experience-based approaches that integrate spatial organization, user behaviour, and caregiver participation to create more inclusive, responsive, and user-centred healthcare environments.

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