Language Structure of Cesarean Section Indications and Its Institutional Expansion During the COVID-19 Pandemic:
Emergency Guideline Elasticity Theory (EGET)

An Observational Document Analysis in Japan

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Technical Clarification

This paper presents a structural and methodological analysis of emergency obstetric guideline language during the COVID-19 pandemic. It does not constitute personal criticism of any individual clinician, hospital, or guideline committee member. The object of analysis is policy language structure, institutional interpretation mechanisms, and decision-environment conditioning.

The framework is hypothesis-generating and explicitly refrains from causal claims. No patient-level data are used. All materials derive from publicly accessible documents, guideline texts, institutional notices, and national registry statistics.

The purpose of this manuscript is to establish a reproducible theoretical platform — Emergency Guideline Elasticity Theory (EGET) — suitable for subsequent commentary publications and future empirical testing.

Abstract

Background: Institutional expansion—defined as both quantitative increase in C-section application and categorical extension of the target population beyond guideline scope—was observed in Japan during the COVID-19 pandemic. This study: (a) examines which structural features of guideline language facilitated this expansion; (b) introduces the Elasticity Coding Instrument (ECI), a reproducible six-dimension scoring instrument; (c) develops a three-layer Institutional Self-Description Power (ISDP) model; (d) introduces Institutional Constraint Mapping (ICM) as a patient-data-independent structural analysis framework; and (e) integrates Crisis Policy Drift theory (Hacker, 2004; Streeck & Thelen, 2005) to explain the persistence of high-elasticity language across guideline versions.

Methods: Document analysis following Bowen (2009) applied to all six JSOG joint COVID-19 guideline editions (March 2020–December 2021), hospital-issued notices (including Internet Archive records), national survey and NDB data (Shimada et al., 2025), and international guidelines. Matland's (1995) ambiguity-conflict model, Lipsky's (1980)

street-level bureaucracy theory, and five supplementary instruments provide the theoretical framework.

Results: ECI scoring revealed a step-change from ECI = 0 (Versions 1–2) to ECI = 11 (Versions 3–6), concurrent with the surge in C-section rates. International guidelines (WHO, RCOG, ACOG, RANZCOG) scored ECI ≈ 0–1 throughout. Documentary evidence from six facilities confirmed institutional expansion extending to COVID-19-negative close contacts. Rinku General Medical Center documented sustained vaginal delivery as the predominant mode of birth for COVID-19-positive pregnant women in Osaka Prefecture (approximately two-thirds vaginal delivery) under the identical national guideline environment, constituting an internal counterfactual that the elevated national rate was not medically inevitable.

Conclusions: This study explicitly refrains from causal claims. It provides a theoretically grounded, observational foundation with seven testable propositions for future hypothesis-testing research.

Keywords: *COVID-19; cesarean section; guideline language; elasticity coding instrument (ECI); institutional expansion; Institutional Self-Description Power (ISDP); Institutional Constraint Mapping (ICM); Emergency Guideline Elasticity Theory (EGET); Crisis Policy Drift; pandemic preparedness; Japan; policy implementation; street-level bureaucracy*

1. Introduction

The COVID-19 pandemic posed unprecedented challenges to perinatal care worldwide. One of the most critical decisions faced by obstetric facilities was the choice of delivery mode for COVID-19-positive pregnant women. With limited early evidence, clinical practices diverged substantially across countries.

Major international obstetric societies—including the WHO, RCOG, ACOG, ISUOG, and RANZCOG—consistently affirmed that COVID-19 status alone does not constitute an indication for cesarean section (C-section). This position rests on the principle that delivery mode decisions should be individualized according to each patient's medical circumstances.

Japan's experience followed a different trajectory. The JSOG pregnancy registry and national survey data recorded C-section rates of 83% in Wave 1 (2020) among term-positive women, followed by 62–84% in Waves 2–5 and 38–67.5% in Waves 6–7. A recent NDB data analysis confirmed a statistically significant nationwide increase in C-section rates during the pandemic period (Shimada et al., 2025).

The concept of "institutional expansion" denotes two related phenomena: (1) quantitative expansion—the overall increase in C-sections during the pandemic period; and (2) categorical expansion—the documented extension of default C-section policies to patient populations not addressed in any JSOG guideline version, most notably COVID-19-negative close contacts. Understanding how such expansion occurs—and persists—requires both textual examination of the guidelines and a theoretical framework for understanding how policy language shapes frontline implementation and institutional norm formation.

This study introduces Emergency Guideline Elasticity Theory (EGET) as an integrated analytical platform comprising five instruments: (1) the Elasticity Coding Instrument (ECI), a six-dimension operationalization of guideline language properties; (2) a three-layer Institutional Self-Description Power (ISDP) model; (3) Institutional Constraint Mapping

(ICM); (4) the primary frameworks of Matland (1995) and Lipsky (1980); and (5) Crisis Policy Drift theory (Hacker, 2004; Streeck & Thelen, 2005), which explains why Versions 4–5 retained high-ECI language despite the accumulation of evidence from Waves 1–3—inaction as a form of policy choice that perpetuated expanded practice.

This study is not designed to establish causal relationships. It is positioned as an observational, hypothesis-generating case study providing seven testable propositions for future empirical and comparative research.

2. Methods

2.1 Study Design

This is an observational policy case study following the document analysis approach described by Bowen (2009), who identifies document analysis as a legitimate and systematic qualitative research method for examining the nature and function of institutional documents as primary data sources. Yin's (2018) case study methodology informs the overall structure. All sources are institutional or governmental public documents; no ethics review for human subjects research is required. All Japanese-language source documents were translated into English by the author; original Japanese text is retained in citations.

2.2 Documents Analyzed

Inclusion criteria: (a) publicly available primary institutional or governmental documents; (b) direct relevance to delivery mode policy for COVID-19-positive or close-contact pregnant women in Japan; (c) published, issued, or archived between January 2020 and December 2023. Documents were identified through systematic searches of official institutional websites, the Internet Archive (archive.org), and Google Scholar. No documents were excluded on the basis of content inconsistency with the study's hypotheses.

Documents analyzed: (1) all six JSOG joint guideline editions (March 2020–December 2021); (2) Handa Municipal Hospital notice (Internet Archive capture); (3) Rinku General Medical Center bulletin (Ogita, 2022) and Furuya et al. (2024) emergency caesarean section case series from Rinku General Medical Center; (4) JSOG registry and national survey C-section rate data; (5) NDB analysis (Shimada et al., 2025); (6) international guidelines from WHO, RCOG, ACOG, ISUOG, and RANZCOG; (7) notices from Tokyo Women’s Medical University Yachiyo Medical Center (April 2020), University of Tokyo Hospital (May 8, 2023), Yokota Maternity Hospital, and Wakayama Rosai Hospital (June 2022).

2.3 Analytical Framework

Documents were analyzed across three dimensions: (1) policy content analysis using ECI scoring; (2) implementation-gap analysis using Matland's (1995) model and the three-layer ISDP model; and (3) counterfactual analysis using ICM. Crisis Policy Drift theory informed the analysis of why high-ECI language persisted across guideline revisions.

2.4 Elasticity Coding Instrument (ECI) — Operationalization

The Elasticity Coding Instrument (ECI) assigns a score of 0–2 on each of six dimensions, producing a total of 0–12. Low elasticity = ECI ≤ 4; Moderate = 5–7; High = ≥ 8.

D1 — Criterion type: 0 = medical indications only; 1 = mixed; 2 = non-medical / resource-allocation criteria predominate.

D2 — Modal construction: 0 = prohibitive ('no indication'); 1 = neutral factual; 2 = permissive ('may be considered').

D3 — Clause subject: 0 = patient condition; 1 = mixed; 2 = facility / administration.

D4 — Restriction clause: 0 = explicit scope limit; 1 = implicit limit; 2 = absent.

D5 — Population definition: 0 = explicit target population; 1 = partial specification; 2 = absent.

D6 — Monitoring provision: 0 = mandatory reporting mechanism; 1 = advisory; 2 = absent.

Scores are summed to produce the ECI total. Two independent coders should score each version; inter-rater reliability should be calculated (Cohen's κ). In the present study, scoring was conducted by the author; independent verification is identified as a priority for future validation.

3. Results

3.1 Evolution of JSOG Guideline Language and ECI Scoring

The joint guidelines were issued in six versions from March 2020 to December 2021 (Table 1). Versions 1 and 2 scored ECI = 0: low ambiguity, low conflict, administrative implementation in Matland's (1995) terms—language aligned with WHO, RCOG, ACOG, and RANZCOG.

Version 3 (April 7, 2020) introduced the discretionary clause, producing a step-change to ECI = 11: D1 = 2 (resource-efficiency criterion), D2 = 2 (permissive 'may be considered'), D3 = 2 (facility as clause subject), D4 = 2 (no restriction clause), D5 = 1 (pneumonia mentioned but not required), D6 = 2 (no monitoring provision). This clause persisted through Versions 4 and 5 (ECI = 11).

Version 6 (December 2021) described the prevailing situation—'Many facilities are performing C-section to shorten labor management time'—while framing vaginal birth as an option only at facilities with sufficient staffing. ECI remains 11. Crisis Policy Drift theory (Hacker, 2004; Streeck & Thelen, 2005) explains the persistence: the decision to retain high-ECI language through Versions 4–5, despite accumulating Wave 1–3 evidence, constitutes a form of policy drift. Version 6's descriptive normalization further activates Layer 1 ISDP.

Table 1. Evolution of C-section-related language in JSOG joint guidelines (2020–2021)

Ver.	Date	C-section Principle	Key Clause / Language	Matland (1995) Classification
1–2	Mar. 2020	No C-section solely for COVID-19	'There is no evidence to indicate C-section solely on the basis of COVID-19 infection.'	Low ambiguity / Low conflict →

Ver.	Date	C-section Principle	Key Clause / Language	Matland (1995) Classification
				Administrative implementation
3	Apr. 7, 2020	Principle retained; discretionary clause appended	'...C-section to shorten labor management time may be considered, considering facility resources and overall maternal condition including pneumonia.' [Non-medical criterion introduced]	High ambiguity / Low conflict → Experimental implementation
4–5	Jul. 2020 – Aug. 2021	Same as Version 3	Discretionary clause retained unchanged	High ambiguity / Low conflict → Experimental implementation (continued)
6	Dec. 2021	Descriptive normalization	'Many facilities are performing C-section... vaginal birth may be an option at facilities where staffing and environment can be secured.'	Retrospective endorsement; Layer 1 ISDP activated; ambiguity maintained

Note: Ver. = Version. 'Labor management time' (分娩管理時間) = duration of active management for vaginal delivery. Matland classification from the ambiguity-conflict model (1995).

Table 2. Elasticity Coding Instrument (ECI) — JSOG guideline version scoring

Version	D1 Criterion	D2 Modal	D3 Subject	D4 Restriction	D5 Population	D6 Monitoring	Score	Level
1–2	0 Medical only	0 Prohibitive	0 Patient	0 Explicit limit	0 COVID-positive	0 Implied	0	Low (0)
3	2 Non-medical	2 Permissive ('may')	2 Facility	2 Absent	1 Partial	2 Absent	11	High (11)
4–5	2 Non-medical	2 Permissive	2 Facility	2 Absent	1 Partial	2 Absent	11	High (11)
6	2 Descriptive norm	2 Permissive	2 Facility	2 Absent	1 Partial	2 Absent	11	High (11)

Note: D1 = Criterion type; D2 = Modal construction; D3 = Clause subject; D4 = Restriction clause; D5 = Population definition; D6 = Monitoring provision. Each 0–2; total 0–12. Low ≤ 4; Moderate 5–7; High ≥ 8. Author-only coding; independent inter-rater verification recommended. International guidelines (WHO, RCOG, ACOG, RANZCOG) scored ECI ≈ 0–1 throughout.

3.2 Trends in C-section Rates and International Comparison

The JSOG registry records 83% in Wave 1 (2020), 62–84% in Waves 2–5, and 38–67.5% in Waves 6–7. The NDB analysis confirmed a statistically significant increase from 20.27% (pre-pandemic) to 21.19% during the pandemic, peaking at 22.14% in Wave 6 (Shimada et al., 2025). Although the relative increase (approximately 0.92 percentage points) is modest, against an annual delivery denominator in the hundreds of thousands it corresponds, on the order of magnitude, to tens of thousands of additional C-sections relative to the maintained pre-pandemic rate—each carrying irreversible implications for the woman's subsequent pregnancies. Table 3 presents international comparators with approximate ECI levels; RANZCOG (Australia) is included as an additional comparator.

Table 3. C-section rates among COVID-19-positive pregnant women: Japan vs. selected countries (observational data)

Country / Facility	Wave / Period	C-section Rate (%)	Guideline Stance (ECI level)	Notes
Japan (JSOG registry)	Wave 1 (2020)	83%	JSOG Ver. 3–5: High-elasticity (ECI = 11)	Term pregnancies; positive cases only
Japan (JSOG registry)	Waves 2–5	62–84%	Same guideline environment (ECI = 11)	
Japan (NDB)	Wave 6	22.14% overall	Post-reclassification; ECI = 11 through end 2021	Significant increase from pre-pandemic 20.27% (Shimada et al., 2025)
Japan (Osaka facilities)	Aug. 2021 – Feb. 2023	~33% C-section (~67% vaginal, Osaka Prefecture)	Same national guidelines (ECI = 11); facility-level SA policy	Internal counterfactual
United Kingdom (MBRRACE)	2020	~36%	RCOG: 'COVID-19 alone is not an indication' (ECI ≈ 0–1)	All caesarean deliveries incl. obstetric indications; not directly comparable
United States (ACOG)	2020–2021	31.8% (total, all births)	ACOG: COVID-19 status alone does not necessitate C-section (ECI ≈ 0–1)	Total CS rate, all births, not COVID-positive subgroup (CDC NVSS, MMWR 2021;70:1686). No nationwide policy of CS for COVID status alone.
Australia (RANZCOG)	2020–2021	37% (total, 2020)	RANZCOG: Individualized decision-making affirmed (ECI ≈ 0–1)	Total CS rate, all births, not COVID-positive subgroup (AIHW,

Country / Facility	Wave / Period	C-section Rate (%)	Guideline Stance (ECI level)	Notes
				Australia's mothers and babies; 41% by 2023). No policy of CS for COVID status alone.

Note: Figures reflect heterogeneous definitions and populations; direct comparison is limited. The Japan rows report C-section rates among COVID-19-positive pregnant women (JSOG registry) or pandemic-period totals (NDB); the US, UK and Australia rows report total C-section rates across all births (government statistics), which are structurally higher and not COVID-specific. The relevant cross-national contrast is therefore NOT the level of the total C-section rate (which is in fact higher in the US and Australia than in Japan) but the presence or absence of a guideline-driven policy applying C-section on the basis of COVID-19 status alone: international bodies (WHO, RCOG, ACOG, RANZCOG) affirmed individualized, indication-based decisions (ECI ≈ 0–1), whereas the JSOG joint guidelines introduced high-elasticity discretionary language (ECI = 11) from Version 3. ECI levels for international guidelines are approximate. Osaka row = internal Japanese counterfactual, not nationally representative.

3.3 Expansion of Application Scope — Documented Cases

The central observational finding is the existence of primary documents indicating that C-section was applied as default to populations beyond JSOG guideline scope—specifically, COVID-19-negative close contacts.

3.3.1 Primary Case: Handa Municipal Hospital

Handa Municipal Hospital (reorganized 2024 as Chita Peninsula General Medical Center) posted a patient-directed notice captured by the Internet Archive on September 26, 2021. The relevant passage states:

> *"In cases where a household family member has tested positive for the novel coronavirus and you are identified as a close contact, the response will also involve transfer to the Second Japan Red Cross Hospital or delivery by cesarean section, as with the infectious diseases described above."*

— Head of Department of Obstetrics and Gynecology, Handa Municipal Hospital (Hiroaki Moroi, MD). Hospital notice (Internet Archive capture: September 26, 2021). [Original URL no longer accessible; archived copy accessed February 2026]

This document satisfies all three Layer 2 ISDP conditions: (1) public posting on official website; (2) departmental head signatory; (3) explicit behavioral expectation for all presenting patients in the defined category. The extension to COVID-19-negative close contacts constitutes categorical expansion beyond any JSOG guideline version's stated scope.

3.3.2 Additional Documentary Evidence — Typological Classification

Table 4. Typological classification of documentary evidence for institutional expansion

Type	Facility	Document Date	Key Content	ISDP Layer
Primary	Handa Municipal Hospital (now Chita Peninsula GMC)	IA capture: Sep. 26, 2021	Explicit C-section default for COVID-19-negative close contacts. Signed by Head of Department (Hiroaki Moroi, MD).	Layer 2

Type	Facility	Document Date	Key Content	ISDP Layer
Type 1	Tokyo Women's Medical Univ. Yachiyo Medical Center, Dept. Maternal-Fetal Medicine	April 2020	Cesarean section considered for asymptomatic test-positive cases and for cases where labor begins before test results return, on infection-control grounds; facility lacks an isolation delivery room. Signed by Hospital Director and Perinatal Center Director.	Layer 2
Type 2a	University of Tokyo Hospital, Dept. OB/GYN	Revision: May 8, 2023	Retrospectively confirms prior 'default C-section' policy; announces shift to indication-based practice.	Layer 2 (revision = prior Layer 2 confirmed)
Type 2b	Yokota Maternity Hospital	Accessed Feb. 2026	Explicit statement that C-section will be performed when labor is imminent for COVID-19-positive patients.	Layer 2
Type 2c	Wakayama Rosai Hospital, Dept. OB/GYN	June 2022	PCR-positive patients expected to deliver within designated period assigned C-section.	Layer 2
Type 3	Japan Family Planning Association	Accessed Feb. 2026	Cites JSOG guideline language; states C-section for all COVID-19 infections 'not uncommon'.	Layer 3 (societal norm recognition)

Note: ISDP layers per three-layer model (Table 5). Type 1 = equivalent treatment of close contacts; Type 2 = explicit default C-section institutionalization; Type 3 = public recognition of guideline language as expansion origin. Types 2a–2c date from post-pandemic peak; temporal limitation noted in Section 6.5.

3.4 Counterfactual Observation

Rinku General Medical Center documented institutional success in maintaining vaginal delivery as the primary mode of birth for COVID-19-positive pregnant women under the identical national ECI = 11 guideline environment. As of mid-2022, the facility had accepted over 130 COVID-19-positive pregnancies and achieved 50 vaginal deliveries, with approximately two-thirds of COVID-19-positive pregnant women in Osaka Prefecture delivering vaginally through a coordinated multidisciplinary protocol involving infectious disease, emergency, and pediatric specialists (Ogita, 2022; Furuya et al., 2024). No facility-acquired infections to newborns or hospital-acquired infection clusters were reported through this period.

These observations constitute the empirical foundation for ICM analysis in Section 4.3: the constraint on vaginal delivery at other facilities was institutional (SC position), not medical (SU position).

4. Emergency Guideline Elasticity Theory (EGET) — Integrated Theoretical Framework

Emergency Guideline Elasticity Theory (EGET) integrates the primary frameworks of Matland (1995) and Lipsky (1980) with five supplementary instruments. Table 6 presents the full integrated framework including the Crisis Policy Drift extension from Hacker (2004) and Streeck & Thelen (2005).

4.1 Elasticity Coding Instrument (ECI)

Guideline Elasticity is the degree to which a guideline's language permits institutional interpretive extension without constituting explicit non-compliance. The ECI operationalizes this across six dimensions (Section 2.4), decomposing Matland's (1995) general ambiguity concept into structurally specific, measurable components applicable to emergency clinical guidelines.

The key analytical contribution of ECI is the distinction between general policy vagueness and structural expansion space. JSOG Version 3 is precise in its reference to 'facility resources'—but this precision creates maximum expansion space because the criterion is indefinitely variable across facilities. D1 = 2 and D3 = 2 are the highest-impact dimensions, driving the step-change from Version 2 to Version 3.

Proposition 1 (P1 — Elasticity-Variance): *High-ECI guideline environments (ECI ≥ 8) generate higher inter-facility variance in clinical practice rates than low-ECI environments (ECI ≤ 4) under otherwise comparable conditions.*

Proposition 2 (P2 — Elasticity-Expansion): *High-ECI clauses that reference non-medical criteria (D1 = 2) and are facility-subject (D3 = 2) create structural space for categorical expansion beyond the guideline's intended target population without constituting documentable violation.*

4.2 Institutional Self-Description Power (ISDP)

ISDP is the capacity of publicly issued organizational documents to structure the decision-making environment as institutional norm-setting declarations rather than informational communications. A document constitutes an ISDP event if and only if it simultaneously satisfies: (1) public dissemination; (2) organizational authorization; and (3) explicit behavioral expectation.

These three conditions distinguish ISDP from general organizational communication. An informal clinical memo fails condition (2); a patient FAQ that does not commit the institution fails condition (3). The Handa notice, the Tokyo Women’s Medical University Yachiyo policy, and the University of Tokyo revision notice each satisfy all three.

Table 5. Three-layer Institutional Self-Description Power (ISDP) model

ISDP Layer	Issuing Entity	Three Defining Conditions	Documentary Instantiation	Analytical Function
Layer 1: Guideline ISDP	National professional society (JSOG)	(1) Public dissemination ✓(2) Organizational authorization ✓(3) Explicit behavioral expectation ✓	JSOG Ver. 3 discretionary clause; Ver. 6 descriptive normalization	Sets national experimental implementation space; retrospectively endorses expanded pattern
Layer 2: Facility ISDP	Individual hospital department	(1) Public posting on official website ✓(2) Departmental head signatory ✓(3) Explicit policy statement for presenting patients ✓	Handa; Tokyo Women's Medical Univ. Yachiyo; University of Tokyo revision; Yokota; Wakayama Rosai	Pre-commits facility to default C-section; constrains clinician discretion; structurally conditions patient ICM position
Layer 3: Societal ISDP	Civil society / patient organizations	(1) Public dissemination ✓(2) Organizational authorization ✓(3) Describes behavior expectation as social norm ✓	Japan Family Planning Association document citing JSOG language, characterizing universal C-section as 'not uncommon'	Stabilizes and legitimates expansion at societal level; reduces external correction pressure

Note: All three layers satisfy the three defining conditions but operate at different scope levels. Multiple co-present layers produce cumulative norm entrenchment.

Proposition 3 (P3 — ISDP-Stabilization): *Where Layer 1 and Layer 2 ISDP are co-present, institutional expansion becomes self-stabilizing: individual clinician-level discretion to deviate from the established default is constrained without requiring explicit enforcement.*

Proposition 4 (P4 — ISDP-Correction): *Correcting an ISDP-stabilized expansion requires explicit institutional acts at the originating ISDP layer; informal guidance revisions or individual clinician behavior changes are structurally insufficient.*

4.3 Institutional Constraint Mapping (ICM)

ICM is a patient-data-independent framework for analyzing how institutional policy decisions structurally condition delivery mode availability. ICM replaces autonomy-violation language with the theoretically precise concept of structural conditioning.

ICM does not claim that informed consent was absent, violated, or insufficient at any specific facility. It instead asks a structurally prior question: what was the institutional architecture of delivery mode availability at the facility where the patient presented? This question is answerable from institutional documents without patient-level data.

Structurally Available (SA): Medically feasible and institutionally supported. Vaginal delivery at Osaka facilities = SA for COVID-positive patients.

Structurally Conditioned (SC): Medically feasible but institutionally predetermined to alternative. C-section default at Handa for close contacts = SC for vaginal delivery. The

patient's formal right to decline the default is not eliminated, but the institutional architecture does not support the alternative.

Structurally Unavailable (SU): Medically unavailable. ICM does not apply to SU cases.

The Osaka counterfactual establishes that vaginal delivery was SA—not SU—throughout the pandemic period. SC classification at other facilities reflects institutional constraint, not medical necessity.

Proposition 5 (P5 — ICM-Distinguishability): *The structural position of a delivery mode (SA, SC, or SU) is distinguishable from institutional documents alone, independently of patient-level data, and constitutes a valid unit of analysis for policy research.*

Proposition 6 (P6 — Counterfactual Sufficiency): *The existence of documented SA facilities under identical guideline conditions suffices to establish that SC classification at other facilities reflects institutional constraint rather than medical necessity.*

Proposition 7 (P7 — Elasticity Independence): *Structural elasticity does not require universal application; documented expansion at a subset of facilities under a high-ECI guideline environment constitutes sufficient evidence that the guideline's language structure enabled the expansion.*

4.4 Crisis Policy Drift (Hacker, 2004; Streeck & Thelen, 2005)

Policy drift, as formalized by Hacker (2004) and Streeck & Thelen (2005), denotes institutional change that occurs through non-revision: when the formal text of a policy remains unchanged while its context evolves, the effective meaning and impact of that policy drifts from its original intent. This study applies that established concept to the specific setting of pandemic-emergency guideline maintenance, designating this application "crisis policy drift." The term is used here as an analytical lens for the present case rather than as a pre-existing named theory; it is one expression of the broader institutional non-correction pattern that recurs across the author's analyses of Japanese crisis governance.

In this case study, JSOG Versions 4 and 5 retained the high-ECI (= 11) discretionary clause intact throughout Waves 2–4, during which documented categorical expansion—including application to close contacts—was already occurring. The decision not to revise the clause constitutes, in Hacker's framework, a form of policy drift: the clause's effective scope expanded not through explicit authorization but through the accumulation of Layer 2 ISDP events and routinization at facility level. Version 6's descriptive normalization of the expanded practice completes this drift cycle by retrospectively endorsing what non-revision had permitted.

The institutional isomorphism mechanism identified by DiMaggio & Powell (1983) reinforces this analysis: once a critical mass of high-status facilities had adopted C-section defaults (Layer 2 ISDP), mimetic isomorphism created normative pressure on remaining facilities to conform, independent of guideline intent.

Table 6. Integrated theoretical framework: EGET instruments and theoretical bases

Framework / Construct	Core Concept	Analytical Function	Empirical Anchor
Matland (1995) Ambiguity-Conflict Model	High ambiguity / Low conflict → Experimental implementation	Explains nationwide variation; locally determined outcomes under identical guidelines	Osaka counterfactual under identical ECI = 11 environment
Lipsky (1980) Street-Level Bureaucracy	Coping by routinization under resource constraints	Explains frontline default to C-section scheduling	Japan Red Cross Aichi: 'certainty' and 'defined time frame' rationale (Kato, 2022)
Guideline Elasticity / ECI (this study)	ECI score 0–12 measuring structural expansion space	Operationalizes ambiguity dimensionally; reproducible; prediction-generating	JSOG Ver. 1–2: ECI = 0 → Ver. 3–6: ECI = 11; international: ECI ≈ 0–1
Institutional Self-Description Power / ISDP (this study)	3-layer public declaration model; 3 defining conditions	Explains self-stabilizing character of expansion; distinguishes norm-setting from mere communication	Handa (Layer 2); UTokyo revision (Layer 2 confirmed); JFPA (Layer 3)
Institutional Constraint Mapping / ICM (this study)	SA / SC / SU structural classification of delivery mode availability	Patient-data-independent framework for decision-environment conditioning; replaces autonomy-violation language	Osaka (SA): vaginal birth feasible throughout → SC at other facilities = institutional constraint, not medical
Crisis Policy Drift (Hacker 2004; Streeck & Thelen 2005)	Incremental non-revision of policy produces de facto drift from original intent	Explains why Versions 4–5 retained high-ECI language despite documented expansion — inaction as policy choice	Versions 4–5 unchanged despite Wave 1–3 evidence; Version 6 retrospective endorsement

Note: ECI, ISDP, and ICM are developed in this study as analytical extensions of the Matland and Lipsky frameworks. Crisis Policy Drift integrates existing institutional change theory (Hacker 2004; Streeck & Thelen 2005) to explain guideline non-revision as a policy mechanism.

5. Defense Against Anticipated Objections

This section addresses seven objections organized by theoretical instrument, followed by a structured presentation of the strongest counter-arguments.

5.1 Objections Targeting the ECI

Objection A: 'The ECI is a post-hoc construct designed to fit the observed data.'

Response: The six ECI dimensions are derived from general features of policy language identified in the prior implementation literature (Matland, 1995; Lipsky, 1980) and defined before application to specific guideline texts. The step-change from ECI = 0 (Versions 1–2) to

ECI = 11 (Version 3) and the concurrent onset of elevated rates constitute a predicted, not retrofitted, observation under ECI theory. Independent validation is explicitly recommended.

Objection B: 'ECI cannot demonstrate causation.'

Response: This study explicitly refrains from causal claims. The ECI is a structural characterization of guideline language, not a causal variable. The causal hypothesis is presented as P1 for future testing, not as a study conclusion.

5.2 Objections Targeting ISDP

Objection C: 'Hospital websites are general patient advisories, not institutional policies.'

Response: The ISDP model specifies the three conditions distinguishing institutional norm-setting from general communication. The University of Tokyo revision notice is decisive: it required a formal institutional act to change the prior default, confirming the prior policy was institutionally binding, not merely advisory.

Objection D: 'The Handa case is a single example and may not be representative.'

Response: P7 establishes single-case sufficiency for structural analysis. The six-facility, three-type documentary corpus spanning multiple prefectures substantially exceeds the minimum required to demonstrate the pattern was not idiosyncratic. Nationwide quantification requires a systematic facility survey, identified as a future research priority.

5.3 Objections Targeting ICM

Objection E: 'Patients could refuse the C-section; therefore their autonomy was not constrained.'

Response: ICM does not claim autonomy violation. It claims SC structural classification: the institutional architecture did not support vaginal delivery at SC facilities, regardless of formal consent rights. SA classification was institutionally achievable, as the Osaka facilities demonstrate.

Objection F: 'Without patient data, you cannot draw conclusions about maternal decision-making.'

Response: ICM separates the institutional structure question from the patient-level question. The SC classification follows from institutional documents alone. How that structure affected specific patients' experiences is left to future qualitative research.

5.4 General Objections

Objection G: 'This is a single-country, document-only study; generalizability is limited.'

Response: The study explicitly acknowledges this. Its contribution is theoretical precision: ECI, ISDP, and ICM are reproducible instruments applicable to comparative contexts. The single-country design enables an internal counterfactual unavailable in cross-country comparisons, establishing the institutional rather than medical character of the constraints.

5.5 Strongest Counter-Arguments and Limits of Inference (Kujo Format)

This section presents the strongest plausible counter-arguments in their best form and delineates the limits of inference, to prevent straw-manning and clarify the non-causal scope of this carrier edition.

Counter-argument 1 (Early uncertainty): Early-pandemic uncertainty justified flexible, precautionary interpretation of any guideline clause.

Counter-argument 2 (Facility autonomy): Facility-level autonomy and local governance explain variation; JSOG guideline language was one factor among many.

Counter-argument 3 (Resource scarcity): Staff exposure risk, isolation logistics, and PPE constraints provided independent operational justification for C-section defaults, regardless of guideline language structure.

Response: EGET does not deny these possibilities. It examines whether the structure and persistence of discretionary clauses plausibly widened interpretive bandwidth and facilitated routinization. Temporal concurrence does not establish causation; alternative explanations—medico-legal anxiety, staffing constraints, local incidence patterns—remain plausible. These counter-arguments constitute the primary agenda for future empirical testing of the seven propositions.

6. Discussion

6.1 Guideline Language Design

Whereas RCOG, ACOG, and RANZCOG scored ECI ≈ 0–1, JSOG Versions 3–5 scored ECI = 11, creating high-elasticity conditions. The step-change was driven by D1 (non-medical criterion), D3 (facility as clause subject), and D4 (absent restriction clause). Future emergency guideline committees could test draft clauses against these dimensions before publication, targeting ECI ≤ 4 for any clause authorizing clinical interventions.

6.2 Crisis Policy Drift and Institutional Isomorphism

The persistence of high-ECI language through Versions 4–5, despite accumulating evidence, exemplifies Crisis Policy Drift (Hacker, 2004): non-revision as a policy mechanism. The Version 6 retrospective endorsement completed the drift cycle. DiMaggio & Powell's (1983) institutional isomorphism explains the spread: mimetic pressure from high-status adopter facilities reduced the normative cost of adoption at other facilities, independently of guideline intent.

6.3 Implications for Future Research

Five priority directions: (1) ECI inter-rater reliability testing (Cohen's κ); (2) comparative ECI coding of emergency obstetric guidelines across countries to test P1; (3) systematic facility survey for nationwide quantification of Layer 2 ISDP prevalence; (4) qualitative studies of patient experience at SC vs. SA facilities; (5) clinical records analysis of prenatal documentation at SC vs. SA facilities to test the ICM hypothesis.

6.4 Contextual Factors

Relevant contextual factors include guideline language structure (ECI), infection-control infrastructure availability (primary enabler of SA classification), and organizational preference for predictability (the coping-by-routinization mechanism, Lipsky, 1980; documented at Japan Red Cross Aichi Medical Center as 'certainty' and 'defined time frame'

rationale). The medico-legal anxiety mechanism and blame-shifting dynamics (Hood, 2011) are identified as additional plausible contributors requiring future empirical examination.

6.5 Limitations

Primary document coverage: the Handa Municipal Hospital case is the most detailed primary document. Availability bias: facilities with explicit defaults may have been more likely to post public notices. Temporal heterogeneity: documentary evidence spans the early pandemic (e.g., Tokyo Women's Medical University Yachiyo, April 2020) through the post-peak period (University of Tokyo revision, May 2023); the latter retrospectively confirms the earlier policy but the temporal gap should be noted. ECI validation: author-only scoring; inter-rater testing required. Causal inference: explicitly refrained throughout. Independent researcher status: no institutional affiliation; no conflicts of interest; no funding.

6.6 Cross-Domain Convergence: Institutional Inertia as a Pandemic Policy Pattern

The Crisis Policy Drift identified in this study — whereby JSOG Versions 4 and 5 retained high-ECI language despite accumulating Wave 1–3 evidence — is not an isolated phenomenon. Companion work by the author documents structurally analogous patterns in two adjacent domains of Japanese COVID-19 policy. In the domain of hospital visitation restrictions, Kujo [39] demonstrates that blanket visitor exclusion policies persisted beyond epidemiologically stabilised conditions through identical mechanisms: institutional path-dependence, transparency deficits, and the absence of mandatory periodic review. The concept of Prolonged Precaution Drift (PPD) formalises this as a general institutional failure mode, characterised by a reversal point t* beyond which continued restriction is normatively unjustifiable — a threshold structurally analogous to the point at which the JSOG discretionary clause had accumulated sufficient counter-evidence to require revision but was instead retained.

In the domain of PCR testing policy, Kujo [40] documents that Japan's operational cycle threshold of Ct=45 persisted through at least August 2024 — approximately four years after peer-reviewed evidence established Ct=24–35 as the practical infectivity boundary. This represents a failure of scientific responsiveness structurally identical to the non-revision of JSOG Versions 4–5: in both cases, institutional inertia maintained a policy framework whose evidential basis had been materially undermined, generating compounding downstream harms. Taken together, these three case studies — cesarean section guideline elasticity, visitation ban persistence, and PCR threshold non-revision — constitute a convergent body of evidence that pandemic institutional inertia operated as a cross-domain policy pattern in Japan, warranting integrated analysis in future pandemic preparedness frameworks.

7. Policy Implications

The following are hypothetical recommendations informed by, but not substituting for, empirical research.

7.1 Guideline Language Design (Target: ECI ≤ 4)

Emergency obstetric guidelines should target ECI ≤ 4 for any clause authorizing clinical interventions. Priority dimensions for designers: D1 (use medical criteria only), D3 (center language on patient condition), D4 (include explicit scope restriction). ECI = 0 is achievable by additionally specifying target population (D5) and monitoring provision (D6).

7.2 Monitoring for Crisis Policy Drift

Establishing mechanisms to identify Layer 2 ISDP events—facility notices extending guideline scope—during emergencies enables early detection of institutional expansion. P4 implies correction requires explicit institutional acts at the originating ISDP layer. Monitoring alone, without a clear correction pathway, is structurally insufficient to reverse ISDP-stabilized drift.

7.3 Infection-Control Infrastructure

Investment in negative-pressure delivery rooms, PPE standardization, and cohorting protocols is the primary structural means of achieving SA classification. The Osaka experience demonstrates this is compatible with infection control. Pandemic preparedness planning should treat this infrastructure as a prerequisite for maintaining guideline integrity, not as a secondary option.

7.4 Maternal Psychological Environment as a Secondary Institutional Domain

The analysis developed in this study concerns the structural conditioning of delivery mode availability. A theoretically adjacent—but analytically distinct—domain concerns the psychological environment of birthing women during the pandemic period. This section identifies potential intersections between EGET constructs and documented maternal mental health patterns without advancing causal claims.

Domestic research has reported that the proportion of postpartum women scoring above the Edinburgh Postnatal Depression Scale (EPDS) clinical threshold—approximately 10% in the pre-pandemic period—rose to an estimated 25–30% by 2021. Notably, elevated scores were reported to be disproportionately concentrated among women who experienced involuntary changes in planned delivery method. Disruption to mother-infant bonding has also been documented in clinical settings: postpartum mothers in emergency-context delivery situations reported elevated rates of difficulty in bonding and fear-based associations with infant contact, with implications for bonding disorder risk. Separate population-level reports document maternal expressions including 'I cannot live as a mother' and 'I became traumatized' in the context of pandemic-period birth experiences.

This study makes no causal claim connecting institutional C-section defaults to these psychological outcomes. The data sources involve different populations, study designs, and analytical units. The temporal co-occurrence—elevated C-section rates and elevated EPDS concentrations among women experiencing unplanned delivery mode changes—is documented but does not, without controlled prospective research, establish a causal pathway.

What EGET contributes to this adjacent domain is a structural vocabulary. Where a facility adopts a C-section default (Layer 2 ISDP; SC structural classification), the delivery mode experienced by presenting patients is institutionally predetermined rather than individually negotiated. Whether this structural conditioning intersects with the psychological experience of birth—and under what conditions—is an empirically open question. The ICM framework generates a testable hypothesis: facilities in the SC position for vaginal delivery will show different distributions of postnatal psychological outcome measures than SA facilities, controlling for obstetric risk factors and pre-existing mental health conditions. This hypothesis is identified as a priority for future interdisciplinary research connecting institutional policy analysis with perinatal mental health epidemiology.

The purpose of this section is not to extend EGET's claims beyond their documented evidentiary basis. It is to delineate the boundary of the theory's potential extensions, to prevent both under-reach (ignoring adjacent evidence streams) and over-reach (asserting causal connections the present study cannot establish). Future Viewpoint and Commentary papers may develop the maternal psychological environment domain as an independent empirical programme, using EGET constructs as the institutional framework and perinatal mental health measures as the outcome domain.

8. Conclusion

This case study demonstrates, through document analysis grounded in Bowen (2009) and interpreted through Matland (1995), Lipsky (1980), and the five EGET instruments developed in this study, that the elevated C-section rates in Japan during the COVID-19 pandemic are associated with institutional factors—guideline language structure, monitoring mechanisms, infection-control infrastructure, and Crisis Policy Drift—whose specific mechanisms can now be characterized with structural precision and submitted to empirical testing.

Three observational findings are analytically decisive. First, a step-change from ECI = 0 to ECI = 11 between Versions 2 and 3, concurrent with the surge in C-section rates and absent in international guideline comparators. Second, multi-facility documentary evidence (six facilities, three evidence types, multiple prefectures) confirming categorical expansion to COVID-19-negative close contacts under the identical high-ECI environment. Third, the Osaka counterfactual establishing vaginal delivery as SA throughout the period, confirming SC classification at other facilities reflects institutional constraint rather than medical necessity.

Seven propositions are offered as specific, testable predictions. This study explicitly refrains from causal claims. Its contribution is to provide EGET—a structurally precise, reproducible theoretical platform—that transforms the question of how guideline language shapes clinical practice from a qualitative observation into a research programme.

Disclosure Statement

Competing Interests

None declared.

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AI Assistance Declaration

The preparation of this manuscript involved the use of Claude (Anthropic), a large language model AI assistant, for literature organisation, theoretical framework development, manuscript drafting, document formatting, and bibliographic verification. All analytical frameworks, core arguments, and intellectual content originated with the human author. The AI was used as a research and writing tool; the author takes full responsibility for the accuracy and integrity of all content. The involvement of AI assistance in producing this manuscript is itself consistent with the argument advanced in Section 7.3:

the analytical failures documented herein were identifiable using tools and reasoning available to any careful observer, specialist or otherwise.

Data Availability

All data used in this analysis are derived from publicly available government reports, peer-reviewed publications, hospital notices (including Internet Archive records), and national registry statistics cited in the References. No proprietary or unpublished data were used. All documents are identified with full source URLs, archive capture dates, and access dates as specified in the References.

Disclosure Statement

The author is an independent researcher with no academic affiliation. No funding was received for this work. No competing interests are declared. The author has no financial relationships with any commercial entity relevant to this manuscript.

AI Assistance Declaration

The preparation of this manuscript involved the use of Claude (Anthropic), a large language model AI assistant, for literature organization, manuscript drafting, and document formatting. All analytical frameworks, core arguments, and intellectual content originated with the human author. The AI was used as a research and writing tool; the author takes full responsibility for the accuracy and integrity of all content.

The involvement of AI assistance in producing this manuscript is itself consistent with the argument advanced in Section 7.3: the analytical failures documented herein were identifiable using tools and reasoning available to any careful observer, specialist or otherwise.

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All documents are identified with full source URLs, archive capture dates, and access dates as specified in Section 2.2 and the References. The Internet Archive captures of hospital notices serve as the primary reproducible evidence base for the ISDP analysis. Institutional documents that have been removed from their original URLs are identified as such; archived copies remain publicly accessible via the URLs provided.

References

[1] World Health Organization. Coronavirus disease (COVID-19): Pregnancy, childbirth and the postnatal period. Updated March 15, 2022. https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-pregnancy-and-childbirth (accessed 2026-02).

[2] Royal College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) infection in pregnancy (guidance; archived/updated). 2020. https://www.rcog.org.uk (accessed 2026-02).

[3] American College of Obstetricians and Gynecologists. COVID-19 FAQs for obstetrician-gynecologists, obstetrics. Updated March 26, 2020. https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics (accessed 2026-02).

[4] Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) and pregnancy. 2020. https://ranzcog.edu.au (accessed 2026-02).

[5] Poon LC, Yang H, Lee JCS, et al. ISUOG interim guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals. Ultrasound Obstet Gynecol. 2020;55(5):700-708. doi:10.1002/uog.22013. PMID:32160345

[6] Japan Society of Obstetrics and Gynecology; Japan Association of Obstetricians and Gynecologists; Japan Society for Infectious Diseases in Obstetrics and Gynecology. COVID-19 response guidelines, Versions 1-6 [Japanese]. 2020-2021. Version 3 (Apr. 7, 2020): https://www.jsog.or.jp/uploads/files/news/20200407_COVID-19.pdf [Internet Archive: https://web.archive.org/web/20260602132331/https://www.jsog.or.jp/uploads/files/news/20200407_COVID-19.pdf]; Version 6 (Dec. 20, 2021): https://www.jsog.or.jp/news/pdf/20211220_COVID-19.pdf [Internet Archive: https://web.archive.org/web/20260602132438/https://www.jsog.or.jp/news/pdf/20211220_COVID-19.pdf]. Versions 1, 2, 4 and 5 are no longer individually hosted on the JSOG site following pandemic-period consolidation; their delivery-policy wording is confirmed via the Version 3 text, Shimada et al. (2025) Table 1, and Sasaki et al. (2023). (accessed 2026-02).

[7] Shimada K, Komiyama J, Sugiyama T, Shin Jung-Ho, Kihara T, Masuda R, Kunisawa S, Iwagami M, Muraki I, Imanaka Y, Iso H, Tamiya N. Changes in proportions of cesarean section before and during the COVID-19 pandemic in Japan. J Obstet Gynaecol Res. 2025;51(7):e16370. doi:10.1111/jog.16370. PMID:40635607. PMCID:PMC12242368

[8] Furuya K, Komatsu N, Tanaka Y, Matsutani K, Sumi M, Yamashita S, Chang Y, Shikado K, Tsubouchi H, Ogita K. Multidisciplinary arrangement for setup and execution of emergency caesarean section for maternal resuscitation due to severe COVID-19: A case series report [Japanese]. J Jpn Soc Emerg Med. 2024;27:669-77.

[9] JSOG Perinatal Committee (Deguchi M, Yamada H). Pregnancy registry system reports on COVID-19 in pregnant women in Japan [Japanese]. 2021-2023.

[10] Japan Association of Obstetricians and Gynecologists, Patient Safety Division. Survey results on delivery response to COVID-19 during Waves 6-7 [Japanese]. September 2022. https://www.jaog.or.jp (accessed 2026-02).

[11] Handa Municipal Hospital, Department of Obstetrics and Gynecology (now Chita Peninsula General Medical Center, following the April 2025 integration into the Chita Peninsula General Medical Organization). Notice to patients planning to deliver at our hospital [Japanese]. Signed by Head of Department, Hiroaki Moroi, MD. Original page: https://www.handa-hosp.jp/important/covid19jouhou/bunbenyotei/ Internet Archive permanent capture: https://web.archive.org/web/20260529140231/https://www.handa-hosp.jp/important/covid19jouhou/bunbenyotei/ (accessed 2026-02).

[12] Rinku General Medical Center (Ogita K). RINKU SMILE facility bulletin [Japanese]. 2022;87:2.

[13] Japan Red Cross Aichi Medical Center Nagoya Second Hospital (Kato N). Protecting lives born during the COVID-19 pandemic [Japanese]. Japan Red Cross NEXT Online. April 2022. https://www.jrc.or.jp/about/publication/news/20220330_024900.html (accessed 2026-02).

[14] Tokyo Women's Medical University Yachiyo Medical Center, Department of Maternal-Fetal Medicine and Gynecology. Policy on delivery management for pregnant women with

suspected or confirmed COVID-19 at our hospital [Japanese]. April 2020. https://www.twmu.ac.jp/TYMC/img/covid_info/covid_info_200428_4.pdf (Internet Archive capture pending; accessed 2026-02).

[15] University of Tokyo Hospital, Department of Obstetrics and Gynecology / Perinatal Center. [Revision] Delivery mode for COVID-19-positive or suspected cases at delivery [Japanese]. May 8, 2023. https://www.obstetrics-htu.jp/news/news_3447/ (accessed 2026-02).

[16] Yokota Maternity Hospital. Delivery arrangements for COVID-19-positive patients [Japanese]. https://www.yokotamaternity.com/info/yokota/covid-19/1619 (accessed 2026-02).

[17] Wakayama Rosai Hospital, Department of Obstetrics and Gynaecology. Delivery management policy during the COVID-19 pandemic [Japanese]. June 2022. https://www.wakayamah.johas.go.jp/whatsnew/12236.html (accessed 2026-02).

[18] Japan Family Planning Association. Childbirth and breastfeeding during the COVID-19 pandemic [Japanese]. https://www.jfpa.or.jp/kazokutokenko/topics/001062.html (accessed 2026-02).

[19] Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. Oxford: Oxford University Press; 2019.

[20] World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. Geneva: WHO; 2016. https://www.who.int/publications/i/item/9789241511216

[21] Knight M, Bunch K, Tuffnell D, et al. MBRRACE-UK: Saving lives, improving mothers' care. Oxford: National Perinatal Epidemiology Unit; 2021.

[22] Debrabandere ML, Farabaugh DC, Giordano C. A review on mode of delivery during COVID-19 between December 2019 and April 2020. Am J Perinatol. 2021;38(4):332-341. doi:10.1055/s-0040-1721658. PMID:33285608

[23] Omar M, Youssef MR, Trinh LN, et al. Excess of cesarean births in pregnant women with COVID-19: a meta-analysis. Birth. 2022;49(2):179-193. doi:10.1111/birt.12609. PMID:34997608

[24] Gurol-Urganci I, Waite L, Webster K, Jardine J, et al. Obstetric interventions and pregnancy outcomes during the COVID-19 pandemic in England: A nationwide cohort study. PLOS Med. 2022;19(1):e1003884. doi:10.1371/journal.pmed.1003884. PMID:35007282

[25] Vousden N, Bunch K, Morris E, et al. The incidence, characteristics and outcomes of pregnant women hospitalized with symptomatic and asymptomatic SARS-CoV-2 infection in the UK from March to September 2020: A national cohort study using the UK Obstetric Surveillance System (UKOSS). PLOS ONE. 2021;16(5):e0251123. doi:10.1371/journal.pone.0251123. PMID:33951100

[26] Bowen GA. Document analysis as a qualitative research method. Qual Res J. 2009;9(2):27-40. doi:10.3316/QRJ0902027

[27] Yin RK. Case study research and applications: Design and methods. 6th ed. Thousand Oaks: Sage; 2018.

[28] Lipsky M. Street-level bureaucracy: Dilemmas of the individual in public services. New York: Russell Sage Foundation; 1980.

[29] Matland RE. Synthesizing the implementation literature: The ambiguity-conflict model of policy implementation. J Public Adm Res Theory. 1995;5(2):145-174. doi:10.1093/oxfordjournals.jpart.a037242

[30] Hacker JS. Privatizing risk without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States. Am Polit Sci Rev. 2004;98(2):243-260. doi:10.1017/S0003055404001121

[31] Streeck W, Thelen K, editors. Beyond continuity: Institutional change in advanced political economies. Oxford: Oxford University Press; 2005.

[32] Boin A, 't Hart P, Stern E, Sundelius B. The politics of crisis management: Public leadership under pressure. Cambridge: Cambridge University Press; 2005.

[33] Conrad P. The medicalization of society: On the transformation of human conditions into treatable disorders. Baltimore: Johns Hopkins University Press; 2007.

[34] DiMaggio PJ, Powell WW. The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. Am Sociol Rev. 1983;48(2):147-160. doi:10.2307/2095101

[35] Spence M. Job market signaling. Q J Econ. 1973;87(3):355-374. doi:10.2307/1882010

[36] Hood C. The blame game: Spin, bureaucracy, and self-preservation in government. Princeton: Princeton University Press; 2011.

[37] Beck U. Risk society: Towards a new modernity. London: Sage; 1992.

[38] World Health Organization. Clinical management of COVID-19: Interim guidance. Geneva: WHO; 2020. https://www.who.int/publications/i/item/clinical-management-of-covid-19 (accessed 2026-02).

[39] Kujo G. Visitor restrictions beyond the emergency phase: lessons from Japan for proportionality and sunset mechanisms. J Med Ethics. Published online 10 Mar 2026. doi:10.1136/jme-2026-111889

[40] Kujo G. Mass PCR screening for COVID-19 in low-prevalence populations: A critical reappraisal of the test-trace-isolate framework proposed for Japan. Zenodo. 2026. https://doi.org/10.5281/zenodo.18724683

[41] Morioka I, Toishi S, Wada Y, et al.; Neonatal Committee, Japan Pediatric Society. Survey on the medical care and management of neonates born to mothers with COVID-19 and its social impact [Japanese]. J Jpn Pediatr Soc. 2023;127(3):519-529. [Facility-level national survey: at the sixth wave, 61% of responding facilities reported “cesarean section as a rule” as their delivery policy for COVID-19-positive pregnant women.]

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