SYMPOSIUM ARTICLE

pa **public administration**   WILEY

The Trump Administration and the COVID-19 crisis: Exploring the warning-response problems and missed opportunities of a public health emergency

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Abstract

This article examines the Trump Administration's inability to mount a timely and effective response to the COVID-19 outbreak, despite ample warning. Through an empirical exploration guided by three explanatory perspectives—psychological, bureau-organizational, and agenda-political—developed from the strategic surprise, public administration, and crisis management literature, the authors seek to shed light on the mechanisms that contributed to the underestimation of the coronavirus threat by the Trump Administration and the slow and mismanaged federal response. The analysis highlights the extent to which the factors identified by previous studies of policy surprise and failure in other security domains are relevant for health security. The paper concludes by addressing the crucial role of executive leadership as an underlying factor in all three perspectives and discussing why the US president is ultimately responsible for ensuring a healthy policy process to guard against the pathologies implicated in the federal government's sub-optimal response to the COVID-19 crisis.

1 | INTRODUCTION

The deadly havoc unleashed by the COVID-19 pandemic has occupied center stage around the world since 2020. In the US alone, the horrifying costs of the pandemic can be measured in the millions of Americans infected with SARS-CoV-2 and the many hundreds of thousands confirmed dead with or from COVID-19 to date (Johns Hopkins University, 2022). While the pandemic came as a rude awakening to many nonspecialists, the predominant view among health security professionals was that the question was not whether but when the next major pandemic or public health emergency would strike. Yet, despite these insights, decades of preparedness work, and considerable investment, President Trump, in March 2020, claimed, "Nobody knew there'd be a pandemic or an epidemic of this proportion. Nobody's ever seen anything like this before" (White House, 2020a). Furthermore, in spite of the fact that he had received abundant warnings, President Trump regularly asserted in his Coronavirus Task Force press briefings that "nobody could have known a thing like this could happen" (White House, 2020b). Such statements could easily be dismissed as self-serving political rhetoric, but for the fact that not only the words but also the substance of the Trump administration's policy reaction to the pandemic suggest a tragic failure to proactively mount a focused, whole-of-government and whole-of-society response to indications of a rapidly intensifying public health threat.

Like other infamous examples of alleged "surprises" in American history—for example, Pearl Harbor, Sputnik, the 2001 9/11 attacks, Hurricane Katrina, and the 2008 financial crisis—the pandemic was anticipated. Based on past outbreaks (SARS, H5N1 avian influenza, Swine flu, MERS, Ebola, Zika) and regular expert warnings (John Hopkins Center for Health Security, 2019; National Intelligence Council, 2012, 2017; WEF, 2019, 2020), a pandemic was viewed as a high probability and even overdue event within the expert community. Warnings were regularly made in the media (e.g., Yong, 2018), by prominent individuals, such as Bill Gates in a widely viewed 2015 TED talk, and by Trump's own experts, who predicted, based on a 2019 influenza simulation, that the US would be underprepared, underfunded, and would be unable to respond effectively to a pandemic. With over 400,000 deaths in the US as a result of COVID-19, at the time Trump left office, this assessment appears tragically prescient. Multiple studies have concluded that many of the deaths in the US were avoidable. An assessment published in the *Lancet* in February 2021 concluded that 40 percent of the COVID-19 fatalities up to that point could have been averted (Woolhandler et al., 2021, p. 711), and a Columbia University report conservatively estimated that between 130,000 and 210,000 deaths were attributable to the failures of the US government (Redlener et al., 2020).

Once China informed the world of a disease outbreak on December 31, 2019, the Trump Administration's response was marked by downplaying the threat, inaction or partial measures, confusion, and inaccurate public statements. As a result, opportunities to slow the spread by facilitating a vigorous public health response of containment and suppression based on testing, contact tracing, and isolation were missed following the confirmation of the first US case on January 21, 2020. After banning foreign nationals from entering the US, if they had been in China in the prior 2 weeks, on January 31, an apparently overconfident Trump Administration was blindsided by the rapid community outbreak of COVID-19, necessitating a declaration of a national emergency on March 13, 2020. At that time, the federal government remained unable to help states carry out widespread testing—despite Trump's false claims that anyone who wanted a test could get one—and had not addressed the expected massive shortfalls of personal protective equipment (PPE) and ventilators. By March 26, 22 states had issued shelter-in-place orders, and some 1 in 2 Americans were in lockdown. By March 30, the death toll had exceeded 3000 and by May 28, deaths passed the 100,000 mark. At the close of 2020, the US had surpassed 346,000 deaths from SARS-CoV-2 (AJMC, 2021).

This dismal result suggests three important questions: (1) Why do governments (and their leaders) fail to adequately address known vulnerabilities and credible warnings about escalating threats and hazards? (2) Why was the Trump Administration unable or unwilling to respond vigilantly to a long-forecasted pandemic despite widespread awareness of the general threat and credible and conclusive advanced warning regarding the specific COVID-19 outbreak? (3) Can concepts and frameworks culled from the literature on "strategic surprise" help explain preparedness and warning-response failures in the health security domain?

2 | PAST RESEARCH AND POINTS OF DEPARTURE

The analytical framework deployed below is derived from the strategic surprise literature in international relations, which arose from an effort to explain cases such as Operation Barbarossa (the German invasion of the Soviet Union during WWII), Pearl Harbor, and the Arab-Israeli war of October 1973 (Betts, 1982; Dahl, 2013; Francois & Lin, 2021; Jervis, 1976; Kam, 1988; Levite, 1987; Wohlstetter, 1962). A previous effort adapted this literature to the issue area of homeland security and counter-terrorism in an attempt to understand the inability of the US to address known vulnerabilities and threats prior to 9/11 (Parker & Stern, 2002, 2005). We subsequently adapted the approach and applied it also to the domain of natural hazards to study the parallel warning-response problems associated with Hurricane Katrina (Parker et al., 2009). Here we further build on the framework by incorporating additional insights from public administration work on policy failure and the challenges of crisis management (Ansell et al., 2010; Ansell et al., 2021a, 2021b; Boin et al., 2017; Bovens & 't Hart, 2016; Galaz et al., 2011; Howlett et al., 2015; McConnell, 2011; McConnell & 't Hart, 2019; Parker, 2015; 't Hart, 2013; Weible et al., 2020; Widmalm et al., 2019) and apply it to the public health domain.

It should be emphasized that the purpose of this early analysis of how the COVID-19 pandemic caught the Trump administration off guard is not to assign blame retrospectively, but rather to help us better understand what happened—and how things could have been different—and to subject some existing scholarly "tools" for this task to a preliminary empirical plausibility probe (Eckstein, 1975, pp. 108–113; Levy, 2015) in the health security domain. To that end, we examine how the factors identified as significant in past studies of policy surprise and failure featured in the Trump Administration's COVID-19 response and crisis management.

In the following three sections, each of the analytical perspectives of the framework will be introduced, and the potential sources of failure that fall under each of these categories will be utilized to illuminate the early and emerging empirical record from the COVID-19 case in an attempt to understand more systematically what went wrong and why. In the final section, we discuss the key role of executive leadership as an underlying determinant in all three perspectives and why the president is ultimately responsible for ensuring that a healthy policy process is in place to guard against the dysfunctions that contributed to the blunders and mistakes made in the federal government's shambolic initial response to the COVID-19 crisis. We also reflect on the extent to which the factors illuminated by previous studies in other security domains were relevant for health security and suggest avenues for future research.

3 | PSYCHOLOGICAL FACTORS

A number of psychological factors help to explain policy surprises and response failures. Psychological factors can have a major impact on threat perception, receptivity to warning, sense-making, and decision-making (Boin et al., 2017; Parker & Stern, 2002). A variety of "cold" (cognitive) and "hot" (motivational or psycho-dynamic) psychological processes impact—and can distort—the interpretation of information and subsequent calibration of policy (Houghton, 2014; Kahneman, 2011; Kahneman et al., 2021; Yetiv, 2013).

Perception and interpretation of information are intensely colored by beliefs, prior experience, historical analogy, existing expectations, framing (not least of risks), and the individual's current cognitive "set" (Jervis, 1976; Kahneman, 2011; Kahneman et al., 2021; Khong, 1992; Vertzberger, 1990). Furthermore, various motivational biases and dynamics—denial, wishful thinking, severe value conflict, perceived betrayal, etc.—can also influence consequential decisions (Wahlert, 2012; David, 1993, p. 23; Jervis, 1976; Yetiv, 2013). Such motivational forces can dramatically distort information processing and judgment, which can leave decision-making susceptible to multiple potential pathologies of defensive avoidance (procrastination, shifting responsibility, or bolstering the preferred alternative one has selected), which can be immobilizing and inhibit response to mounting warnings of imminent threat (Bovens & 't Hart, 1996; Howlett et al., 2015; Janis, 1982; Janis & Mann, 1977; McConnell & 't Hart, 2019).

In this section, we focus on several related psychological patterns and mechanisms that may help us better understand the origins of the Trump Administration's sluggish and chaotic response to the COVID-19 crisis. These are: (1) insensitivity to threat warnings and overconfidence in preparedness and adopted policy; and (2) denial and wishful thinking. Note that while behavioral and rhetorical congruence (George & Stern, 2002; Khong, 1992) with these patterns is relatively empirically tractable, the operation of individual and collective (e.g., small group dynamics) psychological processes are more difficult to observe and attribute (especially at a distance). Furthermore, multiple psychological mechanisms and alternative motivations can generate the same behaviors, so caution in drawing inferences and conclusions is needed.

3.1 | Threat insensitivity and policy overconfidence

Trump repeatedly claimed that the coronavirus crisis was unforeseeable: "… an unforeseen problem… What a problem. Came out of nowhere" (White House, 2020c). On another occasion, he said, "We're having to fix a problem that, 4 weeks ago, nobody ever thought would be a problem" (White House, 2020d). He then stated at one of his daily briefings, "I would view it as something that just surprised the whole world," adding that it was "uncharted territory" (White House, 2020a). These claims were inaccurate and self-serving. The threat of a pandemic was foreseeable and widely foreseen (Sanger et al., 2020).

Regarding the COVID-19 pandemic, the early warning system worked, and, starting in January 2020, Trump repeatedly received prescient warnings from the intelligence community and officials, such as national security adviser Robert O'Brien, deputy national-security adviser Matthew Pottinger, economic adviser Peter Navarro, and the head of HHS, Alex Azar, among others (Blake, 2020; Harris et al., 2020; Lipton et al., 2020; Woodward, 2021). The alarm had been loudly sounded, and the case for a robust policy response had been made (Woodward, 2021; Wright, 2021). Yet, although Trump eventually came to accept that COVID-19 was a deadly and highly contagious disease, his staff described him as "slow to absorb the scale of the risk and to act accordingly," and one of his closest associates said he was "baffled" by how the crisis had unfolded (Lipton et al., 2020).

Past scholarship on warning-response problems and threat perceptions can help us understand Trump's initial insensitivity and reluctance to take immediate and decisive action. Even if what happened should have been foreseeable, events that catch people off-guard tend to be contrary to their previous expectations and often reveal faulty threat or hazard perceptions regarding acute dangers (Levite, 1987). Ignorance of or inaccurate mental models regarding the probability and potential harms associated with various risks, such as natural hazards or infectious disease, can impede vigilant response and reinforce propensities for inaction (Janis & Mann, 1977; Kahneman, 2011).

Trump was eventually persuaded to adopt a strategy that aimed to keep the coronavirus out of the US by imposing travel limitations on passengers from China (Bergengruen & Hennigan, 2020; Woodward, 2021). Although travel restrictions were thought to be of questionable utility for fighting pandemics, on January 31, 2020, Trump issued an executive order blocking entry to the US from anyone who had been in China in the previous 14 days, but it did not apply to US citizens or residents. In this context, it is interesting to note Trump's predilection for labeling COVID-19 "the Chinese virus" (Viala-Gaudefroy & Lindaman, 2020). Trump's early fixation on the country and city where the virus manifested (Wuhan) may well have contributed to his White House's apparent neglect to consider and attempt to head off alternative pathways for the virus to reach the US, for example, via Europe. Trump's "leaky" China travel ban would turn out to be something of a Maginot line that the incoming virus handily circumvented.

Six weeks later, Trump applied travel restrictions to parts of Europe as well. We now know the virus was already silently spreading in the US, and Trump's poorly designed and implemented orders may have exacerbated the spread by causing legal residents to rush home (Bollyky & Nuzzo, 2020). As cases climbed, Trump's bolstering and refusal to reconsider his decisions continued. Trump expressed confidence that his travel measures were sufficient, resisted more comprehensive measures, and painted a rosy picture of the efficacy of the travel restrictions, telling reporters in February: "We have it very much under control in this country … Very interestingly, we've had no deaths" (White

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House, 2020e). Days later, in a television interview on 25 February, White House economic adviser Larry Kudlow echoed this message, "We have contained this. I won't say airtight but pretty close to airtight" (Bergengruen & Hennigan, 2020).

The overvaluation and apparent overconfidence in the ability of the US to deal with SARS-CoV-2 were not limited to Trump and can be seen in the attitudes of other prominent officials. For example, at a January 24, 2020 Senate briefing on the coronavirus, Robert Redfield, the head of the CDC, assured the senators that "[w]e are prepared for this" (Wright, 2021); events would soon prove him wrong.

3.2 | Denial and wishful thinking

Watching President Trump's response to the unfolding COVID-19 pandemic was to observe a leader acting and communicating in a fashion congruent with psychological denial and wishful thinking (Ball et al., 2021). For months, the president continually attempted to reassure the public—and the stock market—via his statements at public appearances and tweets that the problem was "under control," that it would soon go away, and that vaccines were just around the corner and could be pushed out to a receptive public at WARP speed—despite clear indications and expert assessments to the contrary. Again, however, analytical caution is needed, and behaviors attributable to motivated bias and misperception may conceal deception and conscious misrepresentation for personal or political benefit (Tetlock, 2000).

In other words, a critical question in interpreting and judging the president's crisis communication regarding the COVID-19 pandemic is whether he genuinely believed that happy days would soon return and that the pandemic threat would soon recede due to the reduced travel from China (and subsequently from other countries too), seasonal weather changes, etc.—or whether he simply believed that it was in his own political and/or the general interest to act as if he did. The public record of his remarks (Wolfe & Dale, 2020), revelations from Bob Woodward's March 2020 interviews on Trump's private views about the danger of the virus (Woodward, 2021), and reporting based on interviews with administration and government officials involved in fighting the pandemic (Abutaleb et al., 2020), suggest a complex mix of politically motivated "tactical reassurance," denial, and wishful thinking.

With the publication of Woodward's book in the fall of 2020, new information came to light regarding Trump's private thinking regarding the transmissibility of the coronavirus. It exposed that he was aware it was more lethal than a "strenuous" flu (Woodward, 2021, p. xix). In taped interviews with Woodward, Trump conveyed an assessment of pandemic risk very much at odds with his public statements at the time. "I wanted to always play it down," he told Woodward (2021, p. xviii), "I still like playing it down because I don't want to create a panic."

While the Woodward interview reveals that, by February 2020, Trump had a much firmer grasp of the danger posed by the virus than his public statements indicated, in the same interview, he also said, "I think that that goes away in two months with the heat" (Woodward, 2021: xviii). Even after the 28 of January President's Daily Brief on the magnitude of the threat and additional urgent warnings throughout February, the president initially was unwilling to take comprehensive policy measures beyond travel restrictions to fight the pandemic. According to government officials, Trump's persistent reluctance to take the pandemic seriously and the dysfunctional federal response was compounded by "a president perpetually in denial" with a "proclivity toward magical thinking" (Abutaleb et al., 2020).

Even after Trump was persuaded by his experts (Coronavirus Task Force members Dr. Deborah Birx and Dr. Anthony Fauci as well as CDC head Dr. Robert Redfield among others) to take more comprehensive measures and announced his "15 Days to Slow the Spread" campaign (March 16, 2020) and then extended it for another 30 days (March 29, 2020), denial and wishful thinking soon undermined his resolve. Already in April, as cases surged, he started publicly to question the need for his measures, falsely stating that "[i]t is going away" (White House, 2020f) and, in May, he claimed that "with or without a vaccine, it's going to pass, and we're going to be back

to normal" (ABC News, 2020). But, as we will discuss in the final section, Trump's agenda was to open the country regardless of the facts on the ground (Woodward, 2021, p. 353).

4 | BUREAU-ORGANIZATIONAL FACTORS

Insights from this perspective highlight numerous problems contributing to policy failure and increased vulnerability to sub-optimal policy outcomes. Among these are factors associated with problematic organizational arrangements (structures, processes, plans, procedures, delegation of authority, administrative culture, etc.), which can create difficulties with regard to cooperation, coordination, and policy attainment (Comfort et al., 2020; Jordana & Triviño-Salazar, 2020; Kettl, 2003; Parker et al., 2009; Parker & Stern, 2002; Persson et al., 2017). In addition, archaic forms of intergovernmental relations, bureaucratic conflict, political infighting, and capacity loss can hinder or distort communication, information sharing, goal formation, and policy implementation (Kam, 1988, pp. 176–198; Agranoff & McGuire, 2001; Fowler, 2020; Ansell et al., 2021a, 2021b). We will now utilize the bureaucratic-organizational perspective to shed light on the subpar governmental performance related to swiftly mounting an effective all-of-government approach to the COVID-19 pandemic.

4.1 | Organizational complexity and coordination problems: The slow and ineffective response

Complex emergencies and extreme events often exceed the capacity of any single organization to manage on its own and necessitate multiple organizations to work in concert. In addition, disruptive events and crises, such as a pandemic, require involved organizations to combine and coordinate their efforts, horizontally and vertically, to respond effectively to the needs of the situation (Aldrich, 2019; Boin & Bynander, 2015; Christensen et al., 2016; Nohrstedt et al., 2018). Therefore, the plans, procedures, and capabilities for timely and effective sense-making, coordination, up-scaling, and supply logistics to deploy critical resources and expertise across organizations, levels, and sectors are essential dimensions of a crisis response system. (Ansell et al., 2010; Boin et al., 2017; Parker et al., 2019; Parker et al., 2020).

In the US system, states and their local authorities have the primary "front-line" responsibility for public health emergencies, as they do in other types of disasters (Kettl, 2003; Parker et al., 2009). However, dating back to the establishment of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1950 and the creation of FEMA in 1979, the federal government has significant responsibilities for managing national emergencies (Kapucu & Hu, 2022). As no state has the capacity to manage the nationwide consequences of a pandemic, national strategies have envisaged a crucial role for the federal government (see, for example, the Bush administration's 2005 pandemic preparedness plan).

At the federal level, the problem of pandemic response cuts across the mandates of many departments and agencies, including the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the FDA, the Federal Emergency Management Agency (FEMA), the Environmental Protection Agency, the NSC, and other federal government entities, as well as requiring cooperation and coordination with state and local health authorities. It also includes thousands of hospitals and can consist of volunteer organizations, such as the Red Cross. Because the Trump Administration response was poorly led and managed in important respects, it was not able to overcome this organizational fragmentation and mount a coherent and effective federal response to the COVID-19 crisis (Kapucu & Hu, 2022; Kapucu & Moynihan, 2021; Kettl, 2020; Rozell & Wilcox, 2020).

In recognition of this organizational complexity, the Obama Administration built on the Bush-era plans by creating an NSC "Playbook for Early Response to High-Consequence Emerging Infectious Disease Threats and Biological Incidents" (Executive Office of the President, 2016), which it passed on to the Trump Administration. The playbook

provided a detailed 69-page guide with clear instructions and procedures to facilitate a smooth all-of-government response to a pandemic. The document identified the involved actors, cataloged available resources, and offered a list of specific questions that should be asked and decisions that should be made at multiple levels in the federal government.

The Trump Administration opted to shelve the NSC playbook and, in 2018, shutter NSC's Directorate for Global Health Security and Biodefense—which created the playbook and previously had the responsibility for supporting the White House's pandemic response (Diamond & Toosi, 2020). The Trump Administration replaced the playbook with its own set of plans centered on the revised 2018 Pandemic Crisis Action Plan (PanCAP) (FEMA, 2021). However, the 2019 HHS's Crimson Contagion influenza pandemic simulation revealed the Trump administration's arrangements to be woefully unprepared for the challenge. HHS found it difficult to serve as the lead federal agency, other federal agencies were confused about who was in charge, federal interagency coordination performed poorly, and participating states were frustrated with processes for securing resources (New York Times, 2019, p. 55). All of these problems played out in real-time when the Administration was actually faced with responding to the rigors of the COVID-19 pandemic.

After China's initial January 2020 announcement, a suite of measures, along the lines outlined in the response playbook, should have been launched. However, even after cases were confirmed in the US and the WHO had declared a global health emergency, the Trump Administration's response was sluggish and largely ad hoc. When it came to the steps recommended in the 2016 playbook—to move quickly to detect outbreaks, take measures to limit the spread of disease, scale-up logistics to help with the shortfall of critical resources such as personal protective equipment, and coordinate a unified all-of-government response—the Trump Administration lagged at every juncture or failed to deliver. In the absence of guidance from a properly implemented preparedness plan or top leadership, the actors crucial for an effective federal pandemic response were unable to get on the same page to coordinate and cooperate (Kapucu & Hu, 2022; Rozell & Wilcox, 2020). Instead, there was vicious infighting within and between the White House, HHS, the CDC, and FDA about setting shared goals over testing and which nonpharmaceutical measures to prioritize (Diamond, 2020). The Trump Administration did not declare COVID-19 a national emergency until March 13, 2020 and, even after doing so, struggled to produce coherent, effective policies concerning mass testing, lockdowns, masking, and public communication.

4.2 | Bureaucratic politics, turf concerns, and SOPS: The testing failure

Bureaucratic politics and organizational process scholarship (Allison & Zelikow, 1999; Stern & Verbeek, 1998), with its focus on turf concerns and SOPs, highlight key factors that contributed to America's initial testing fiasco. Rapidly standing up an effective testing system is essential to containing infectious disease outbreaks, and the Trump Administration's failure to do so left public health authorities blind to the spread of the virus and essentially made duplicating the containment and suppression strategy that was working well at the time in places like South Korea impossible (Gottlieb, 2021; Thompson, 2021). The federal government declined to use the COVID-19 diagnostic test approved by the World Health Organization (WHO). Instead, the CDC insisted on developing its own test and then botched the job. The CDC and the FDA also worked against quickly approving effective tests from commercial labs outside the government.

The bureaucratic politics literature views policy outcomes driven by power struggles among bureaucratic interests and highlights how turf concerns and organizational parochialism can affect decision-making and stymie collaboration with other organizational actors (Allison & Zelikow, 1999; Vertzberger, 1990). When faced with a crisis, responsible organizations can opt to collaborate with other partners to facilitate collective action or rely more strictly on themselves and their pre-existing preferences (Kapucu, 2006; Parker et al., 2020). When confronting the SARS-CoV-2 testing challenge, the CDC initially spurned collaboration and instead jealously guarded its turf and protected its narrow self-interests, with unfortunate consequences.

The CDC did not think it needed an outside test and rejected adopting the WHO's test or help from outside scientists and labs (Kenen, 2020; Shear et al., 2020a). Moreover, rather than collaborating with the commercial labs, the CDC actively worked to obstruct them from developing and deploying their own tests by, for example, refusing to share its virus samples with commercial labs, which hindered test development because it "didn't view it as a part of its mission to assist these labs" (Gottlieb, 2021, p. 124). The CDC also required all testing to be conducted by its labs despite lacking the capacity to deal with the levels of testing needed and prioritized protecting its intellectual property and test royalties rather than rapid production when negotiating contracts with companies to manufacture tests (Gottlieb, 2021, pp. 112, 175).

After protecting its turf and deciding to make a test itself, the CDC's initial tests failed to work. The origins of this debacle can be traced to the CDC's failure to follow standard operating procedures (SOPs) in its labs, resulting in contamination and ineffective tests (Willman, 2020). According to the FDA, the "C.D.C. did not manufacture its test consistent with its own protocol," and the violations of its safety standards allowed the distribution of tests that did not work to most of the 100 state and local public health labs throughout the country (Kaplan, 2020).

The failure of the CDC to quickly produce, manufacture, and extensively distribute working tests could have been partially alleviated with the assistance of scientists, labs, and companies outside of the government. However, the FDA's inability to relax the regulatory hurdles of its approval SOPS frustrated efforts to increase the country's testing capacity rapidly. As the *New York Times* reported, although "researchers around the country quickly began creating tests that could diagnose Covid-19, many said they were hindered by the F.D.A.'s approval process" (Shear et al., 2020a). Despite some efforts to be responsive, the FDA too proved to be a hidebound organization and displayed poor adaptive capacity. Rather than dramatically altering its rules to accelerate the approval of testing, it only tinkered with its burdensome regulatory requirements, resulting in lengthy delays in allowing qualified medical centers to deploy their own tests (Kenen, 2020; Shear et al., 2020a).

The US eventually was able to conduct more than 2 million tests per day, but, due to infighting and intra and inter-bureaucratic conflict in and between the White House, HHS, the CDC, and the FDA, the federal government was never able to agree to joint goals that prioritized, funded, and created a nationwide mass testing capacity to the extent that experts said was needed to effectively track and contain the virus (Thompson, 2021).

5 | AGENDA-POLITICAL FACTORS

Decision-makers and organizations operate within a particular political context, and leader priorities and politicization can have a profound impact on policy action or inaction (Handel, 1984, pp. 251–258; George & Holl, 2000, pp. 24–25; Betts, 2003; Howlett et al., 2015). Moreover, government nondecisions, opting not to act or to delay action, can be just as, or even more, consequential than decisions to act (Weible et al., 2020, p. 228; McConnell & 't Hart, 2019).

To demonstrate the influence and dynamics of politicization on why the Trump Administration downplayed warnings, failed to pursue an effective containment strategy, and was reluctant to implement comprehensive mitigation policies, in this section, we draw on the insights from the agenda-setting literature and the scholarship focusing on security and threat politics (Eriksson, 2001; Kingdon, 1995). This body of work helps to explain why some problems and threat images at any given time are accorded a high degree of "salience" and what role focusing events can play in driving agenda and policy change (Birkland, 1998; Eriksson, 2001; Kingdon, 1995; Resodihardjo, 2021).

Whether a policy issue is acted upon depends upon the amount of attention and resources received from bureaucrats, politicians, the media, the public, academia, pressure groups, and political leaders. Thus, it is crucial to examine which actors are involved in issue definition and agenda-setting and to what extent and why their advocacy influences policy, especially when it comes to triggering or failing to trigger policy action. This perspective emphasizes advocacy and the conditions under which framing actors do or do not have a policy impact (Birkland, 1998; Eriksson, 2001; Kingdon, 1995; Nohrstedt, 2013; Resodihardjo, 2021).

The agenda-politics perspective points to three factors that shed light on the Trump Administration's policy response to the COVID-19 crisis: overcrowded agendas, misplaced political priorities, and threat framing contests.

5.1 | Overcrowded agendas and competing priorities

The agendas of presidential administrations are habitually overloaded. Myriad issues compete for the scarce time and attention of the president, advisers, staff, and cabinet members. Policymakers tend to devote time to issues selectively and sequentially rather than concurrently and comprehensively (March, 1994). When a new problem or risk arises, it can take time for decision-makers to reorient their priorities. Even in the face of an urgent crisis, uncertainty and the tendency to frame events in ways that buttress existing beliefs and preferences can render policy actors resistant to changing priorities (Baumgartner & Jones, 1991; Nohrstedt et al., 2021; Weible et al., 2020). Political leaders, particularly in election years, will also be extremely sensitive to how a crisis might impact their political fortunes (Boin et al., 2021, p. 75).

At the outset of the pandemic, Trump was under impeachment. The impeachment trial began in the US Senate on 16 January 2020 and ended with his acquittal on February 5. On January 3, the US carried out a drone strike ordered by the president that killed top Iranian general Qasem Soleimani in Baghdad. A round of tough trade negotiations with China concluded with Trump signing the first phase of a US-China trade deal on January 15. In addition, Trump was preparing for and, on February 4, gave his State of the Union address. Trump also attended the Davos, Switzerland World Economic Forum in late January and traveled to India for a state visit in February.

Throughout the COVID-19 crisis, Donald Trump's lodestar priority was his bid for reelection (Rucker & Dawsey, 2020; Woodward, 2021). Trump's 2020 campaign centerpiece was that he had made America great again by delivering a strong economy, low unemployment, and a rising stock market. At his February 4, 2020 State of the Union address, Trump made his case: "Jobs are booming, incomes are soaring, poverty is plummeting, crime is falling, confidence is surging, and our country is thriving … America's fortunes are on the rise, and America's future is blazing bright" (CNN, 2020). In that same speech, he briefly mentioned the coronavirus, promising to fight infectious diseases, work together with China on the outbreak, and to "take all necessary steps to safeguard our citizens from this threat" (CNN, 2020). In fact, Trump and some of his closest advisors were reluctant to enact intrusive measures (mass-testing and nonpharmaceutical interventions), preoccupied with how public statements and policies would affect the stock market and his approval ratings, and obsessed with how the optics of the pandemic and the federal government's response would affect Trump's bid for reelection (Diamond, 2020; McGraw & Oprysko, 2020; Shear et al., 2020c; Woodward, 2021; Wright, 2021).

5.2 | Framing contests and framing failures

Significant problems will not be dealt with if they are not framed in a compelling way that convinces the top decision-makers to act, given competing priorities and overcrowded agendas. This problem can be exacerbated when the proponents of an issue or a particular policy option (such as those who were adamant that the US reopen after the 45-day shutdown) attempt to strengthen their argument by downgrading the importance of another issue on the agenda (the necessity for mass COVID-19 testing), especially if those issues are seen as competitors. In addition, blame games, driven by the desire to avoid being held accountable for sub-optimal outcomes, can also influence how an issue is framed, which policies are or are not pursued, and can hinder crisis management (Brändström & Kuipers, 2003; Boin et al., 2019, p. 151). Incumbents facing an upcoming election have a strong incentive to shift responsibility and blame others by endogenizing the causes of a crisis (Boin et al., 2021, p. 71–74).

When considering the role framing contests played in affecting how the Trump Administration responded and managed the COVID-19 crisis, it is important to note not only *who* was dominating agenda-setting, but also *how*

issues were framed and presented to the White House, the relevant government departments, and the public. As the ultimate decision-maker and the framer-in-chief, President Trump was simultaneously the principal audience for the framing efforts of government officials and his staff and the key tone-setter for his administration and the public.

Throughout February, some White House officials felt the president and other senior officials were not taking the threat posed by the coronavirus seriously enough and were pressing for Trump to take more aggressive action beyond limiting travel from China (Lipton et al., 2020; McGraw & Oprysko, 2020). Early on, Trump and some of his closest aides saw urgent warnings about the coronavirus from figures such as HSS secretary Azar as alarmist (Lipton et al., 2020). In a White House where officials that presented favorable news were rewarded, and those who delivered unwelcome news were shunned or risked punishment, Trump incentivized officials to highlight the rosiest scenarios in briefings (Diamond, 2020). From the start, Trump made it clear that he wanted the coronavirus case numbers to be as low as possible, emphasizing appearances over situational awareness. When CDC official Nancy Messonnier departed from the Administration's line that everything was under control and bluntly warned that community spread was inevitable and everyday life could be severely disrupted, the stock market fell, and Trump flew into a rage (Woodward, 2021, p. 252).

With cases rising and the stock market plummeting, the president was eventually convinced by advisors and key members of the Coronavirus Task Force that the dangers posed by COVID-19 required more urgent action, and he agreed to support an unprecedented 15-day national shutdown of nonessential activity to slow the spread (McGraw & Oprysko, 2020; White House, 2020g). In a high-stakes 15 March Oval Office meeting, Fauci and Birx, in the face of skepticism from Treasury Secretary Mnuchin, successfully made the case that a shutdown was necessary to flatten the curve (Woodward, 2021, p. 280–281). Trump, sobered by worst-case scenario death projections (McGraw & Oprysko, 2020), accepted Fauci and Birx's public health framing that a shutdown was needed to prevent the health care system from being overwhelmed and save lives (White House, 2020h). Trump was then persuaded to extend the shutdown for an additional 30 days.

In addition to the shutdown, to cope with the economic fallout of the COVID-19 pandemic, Trump supported, and, on March 27, 2020, signed into law, a $2.2 trillion economic stimulus bill, the Coronavirus Aid, Relief, and Economic Security Act (CARES) (AJMC, 2021). The Trump Administration also supported Operation Warp Speed (OWS), which provided funding to facilitate and accelerate the development of a COVID-19 vaccine.

Already in April, however, prior to the end of the shutdown, Trump and key aides, such as White House chief of staff Mark Meadows, had decided, as Trump had written in an earlier tweet, that the coronavirus cure could not be "be worse than the problem itself" (Woodward, 2021, p. 289). From that point on, throughout the summer, and until election day, Trump would frame the COVID-19 crisis as a fading problem that was soon going away; blame China for failing to stop the "China virus;" tout false remedies such as hydroxychloroquine; undermine state mitigation measures and encourage protestors by tweeting "Liberate Minnesota," "Liberate Michigan," and "Liberate Virginia;" question the need for wearing masks; make strange statements such as suggesting COVID-19 could be treated by injecting disinfectants; and tell the public and his officials that he wanted testing to be slowed down because more testing would find more cases (Shear et al., 2020c; ABC News, 2020; Rucker & Dawsey, 2020; Woodward, 2021).

How an issue is framed and acted upon is often dependent on influential policy entrepreneurs, which, in turn, is dependent upon access to the president (Parker & Stern, 2005, p. 319). Once President Trump decided to reopen the country, he marginalized figures like Fauci and Birk in favor of key advisers, particularly chief of staff Mark Meadows and Scott Atlas, a neuroradiologist, who were promoting an overly optimistic view of the pandemic and were skeptical of the need for nonpharmaceutical interventions (Wright, 2021). Atlas, who had caught Trump's attention as a regular on Fox News, joined the coronavirus task force in August 2020. After his arrival, Trump stopped listening to the government's public health experts (Shear et al., 2020b; Wright, 2021). The *New York Times* reported that the way Atlas framed the situation was "exactly what the president wanted to hear: The virus is overblown, the number of deaths is exaggerated, testing is overrated, lockdowns do more harm than good" (Shear et al., 2020b). From that point on, it would be primarily the views of Atlas, rather than other public health officials, that would shape the White House's coronavirus response and public messaging.

The framing contests and agenda politics that played out in the White House help illuminate why Trump and his Administration neglected proven methods of fighting a pandemic drawn from lessons that dated back to 1918 about instituting nonpharmaceutical measures and clearly, consistently, and accurately communicating to the public about the necessary measures to fight the pandemic (Barry, 2009).

6 | CONCLUSIONS

We began this article by posing three questions: (1) Why do governments (and their leaders) fail to adequately address known vulnerabilities and credible warnings about escalating threats and hazards? (2) Why was the Trump Administration unable or unwilling to respond vigilantly to a long-forecasted pandemic despite widespread aware-ness of the general threat and credible and conclusive advanced warning regarding the specific COVID-19 outbreak? (3) Can concepts and frameworks derived from the literature on "strategic surprise" help explain preparedness and warning-response failures in the health security domain?

To explore the first question, we deployed a tripartite framework based on our previous work on warning-response failure (Parker et al., 2009; Parker & Stern, 2002, 2005), emphasizing a combination of psychological (cogni-tive and motivational bias), bureau-organizational (organizational fragmentation, competition, and turf concerns), and agenda-political factors (prioritization of attention and resources and competitive framing). This literature suggests that discernible patterns of denial, disorganization, and distraction, as well as bureaucratic conflict, and the politiciza-tion of threat assessment and policy measures go a long way in explaining historical warning-response failures.

Regarding the second question, factors associated with these three perspectives shed considerable light on the dynamics that contributed to the Trump Administration's failure to proactively address the threat and effectively manage the pandemic and—by extension—to the comparatively high toll of lives lost in the US during that period. As suggested in the apt title of a recent paper by Platje et al. (2020), the COVID-19 pandemic appears to have been "both an expected and unexpected event." However, many of the critical challenges that vexed the Trump Adminis-tration's response were not only foreseeable but were, in fact, foreseen.

The empirical results from this study of the Trump Administration's response to the COVID-19 pandemic, much like the ones reported from previous cases of strategic surprise and policy failure, such as 9/11 or the Hurricane Katrina response (Parker et al., 2009; Parker & Stern, 2002, 2005), suggest that leadership is a key underlying deter-minant in all three perspectives. Leaders, like their followers, are human and susceptible to the various forms of cog-nitive and motivational biases outlined above. Furthermore, leaders set the tone not only for their advisory groups and networks but to a large extent for the wider executive branch bureaucracies as well (George & Stern, 2002; Preston, 2001; Preston & 't Hart, 1999; Stern & Sundelius, 1997).

Malignant forms of bureaucratic politics flourish and organizational logjams persist when leaders (or their surro-gates) fail to create a transparent interagency decision-making process, cut through the red tape, or set constructive norms for policy discourse (Rosati, 2000). Donald Trump and his top officials failed to provide scientifically informed, normative leadership, resulting in fierce infighting between multiple power centers, blame-shifting, ambiguity regard-ing who was in charge, and a delayed, disorganized response to the pandemic.

Finally, from an agenda-political perspective, although others may be more or less skillful in securing access and making their cases for preferred policies, the buck stops in the Oval Office. The definitive duty for setting the politi-cal and policy agenda rests with the White House. When the executive initially suggests that the stock market and not public health is of the utmost importance and makes it clear that bad news is unwelcome, shifting priorities and rapidly responding and adjusting to new information becomes difficult. At the end of the day, presidents are respon-sible for (although not entirely in control of) the political agenda.

Responding to pandemics is challenging, and many countries struggled to manage the COVID-19 crisis (Boin et al., 2021). It is also important to recognize that not all of the problems of the US response can be laid at the feet of President Trump. As we showed above, the CDC's initial testing failures resulted from institutional ills that were

independent of the president, and the pandemic revealed dysfunction and institutional rot at the CDC and FDA that predated the Trump Administration (Gottlieb, 2021). However, despite favorable circumstances—sufficient early warning, substantial capacity, a venerable center for disease control and prevention, vast resources, high-quality laboratories, and world-leading scientific expertise—the Trump Administration demonstrated incompetence in responding to and managing the SARS-CoV-2 outbreak.

The US, although it represents just 4% of the world's population, accounted for over 20% of all confirmed COVID-19 cases and deaths worldwide that took place on Trump's watch (Johns Hopkins University, 2022). This outcome was not inevitable. With a timelier, focused, scientifically informed, and sustained whole-of-government response, it has been estimated that hundreds of thousands of COVID-19 deaths could have been avoided (Redlener et al., 2020; Woolhandler et al., 2021). Ultimately, in the US system, as the commander-in-chief, presidents are responsible for the decisions the federal government makes or fails to make, the mobilization and coordination of the federal response to national crises, and setting and enforcing the proper priorities. In the final analysis, when it comes to assessing responsibility for the avoidable failures of the federal government's COVID-19 performance, the evidence examined here indicates that, while not responsible for everything that went wrong, President Trump was a decisive factor behind the tragically sub-optimal US pandemic response.

Regarding the third question, there are considerable similarities in the patterns underlying warning-response failures in the military, homeland security, emergency management, and health security realms. While perhaps counter-intuitive, this is not particularly surprising as the warning-response framework applied in this paper departs from enduring and empirically well-documented features of the human mind, organizations, and the political environment typical of crisis management in the US and other highly developed countries (OECD, 2015; Parker et al., 2009).

For this reason, a natural next step in this line of research would be to apply the framework systematically to a variety of other contingencies such as cyberattacks and information operations (Francois & Lin, 2021) in order to demonstrate further and delineate the scope—and limitations of applicability—pertaining to the approach and formulate propositions about the relative importance of the "cuts" (and the particular mechanisms identified within them) across issue areas and circumstances. In our view, there is an opportunity for mid-range theory development based on the rigorous comparison of warning-response failures in different policy domains.

Finally, because we are interested in a knowledge base that can contribute to the avoidance of the types of failures analyzed here, like others before us (Bovens & 't Hart, 2016; McConnell, 2011), we believe there is a need for more studies that diagnose both failure and success. Understanding failure remains essential, but there is more work to be done with medium-n comparative case designs that study the dynamics of policy success compared with those of failure. The quest to enhance societal security demands we embrace the challenge of learning from crisis management successes and failures.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data derived from public domain resources. The empirics that support the conclusions of this study are publically available primary and secondary source materials that were cited in the paper and appear in the reference list.

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