In the Boardroom: How Do Cognitive Frames Shape American and Dutch Hospitals? Responses to the Pressure of Adopting Governance Best Practices

Introduction

Understanding the different ways in which organizations respond to institutional pressure has been a long-standing concern among institutional scholars. Some such studies proposed that the organizational response is in line with the dependency of the organization on a certain field constituent (Oliver, 1991; Fox-Wolfgramm et al., 1998); while other streams of research suggested that social, political and economic forces are driving these decisions (Kennedy & Fiss, 2009; Westphal et al., 1997). Over the past decade, a growing number of studies have started to investigate the role of individual decision-makers in developing organizational responses to institutional pressure (Liu et al., 2018; Raaijmakers et al., 2015; Bertels & Lawrence, 2016). Moving away from the traditional, organizational level view of responses (Oliver, 1991), this field of research highlighted that individual actors and their interpretation of institutional pressure play an important – yet previously rather studied - role in the development of organizational responses (Liu et al., 2018; Raaijmakers et al., 2015; Bertels & Lawrence, 2016, Bevort & Suddaby, 2016).

Previous studies took different perspectives to examine individuals' interpretation of the institutional environment and their influence on organizational responses. The micro-foundations perspective (Cholakova & Ravasi, 2020) argued that our cognitive structures influence our ability to interpret various demands rising in a complex institutional environment. The identity-based perspective (Wry & York, 2017) focused on how the individuals' identity shape their behavior and actions in a given organizational context. Other streams of research focused on CEO background characteristics and their influence on organizational choices (Hambrick & Mason, 1984; Dezso &

Ross, 2012), individuals' perception of institutional pressure (Toubiana & Ziestma, 2017), and individuals' capacity to understand institutional boundaries (Voronov & Yorks, 2015). While previous research has shown that individuals' interpretation of institutional environment influences development of organizational responses, little is known about what conditions individuals to interpret the environment in particular ways. This is the key concern of this paper.

Our own interest in this topic emerged from a field study of board members of U.S. and Dutch not-for-profit hospitals involved in making choices concerning the adoption of best practices described in codes of good governance. We used the example of board evaluation practices in order to compare the final organizational choices of hospitals in both countries. These board evaluation practices are either part of the health care governance code or designed by constituents of the health care field (e.g. accreditation agencies or governance institutions), as a set of best practices to improve hospital effectiveness and robustness (Eeckloo et al., 2004). All hospitals in our sample had committed to adopting these board governance practices due to the same pressure placed on them. However, those hospitals made distinct choices concerning how they responded to this institutional pressure. To explain these differences in organizational responses, we take the cognitive framing perspective on the individual hospital directors' interpretation of the institutional pressure and their organizational response to adopting board evaluation practices.

Using qualitative data gathered through interviews with board members of different hospitals operating in similar institutional contexts in their own countries and in similar normative contexts in both countries, we examined how board members interpreted the institutional pressures that had shaped their hospitals' choices regarding board evaluation practices. Specifically, our analysis revealed four qualitatively different cognitive frames that board members relied on to

interpret the institutional pressure, and which influenced their organizational choice for certain board evaluation practices. We also found that the individuals' cognitive frames were shaped by the directors' prior experience and role definition. For example, we found that inexperienced board members emphasized the necessity of unconditional compliance with regulations; their cognitive frame stressed the implementation of board evaluation practices as only required by law. We also found that board members with a more experienced health care professional frame pushed the organization to implement recommendations by the code as long as they were meeting the requirements of the organization, instead of advocating a one-size-fits-all approach. Our findings thus suggest that the individual directors' cognitive frames influence the organizational response to the pressure of implementing board evaluation best practices, while these cognitive frames are also shaped by the individuals' experience and role definition.

We advance literature on the role of individual decision-makers in developing organizational responses by showing how actors' interpretation of how to respond to the pressure of adopting a practice depends on their prior experience and role definition. Our analysis of the board members' cognitive frames offers a more nuanced understanding of how they interpret institutional pressure, and ultimately make choices for adopting governance best practices.

Theoretical Background

Directors have always played an important role in shaping organizational actions as a response to internal and external pressures (Johnson et al., 1996). Understanding how these directors make their decisions and what influences their actions in the decision-making process remains a long-standing debate topic among scholars (Boivie et al., 2016). The following sections provide a short overview of the different scholarly perspectives in the literature concerned.

Studies examine the role of the individual characteristics of the individual actors' perception of the institutional environment (Besharov & Smith, 2014; Pache & Santos, 2013) as an input for organizational responses. McPherson and Sauder (2013), for instance, find that individual actors "exercise a great deal of agency" (p. 165) in how they perceive their institutional environment, which elements of the institutional environment they draw on to justify their decisions, and for what purposes. Bevort and Suddaby (2016) suggest that "the individuals' cognition and interpretive subjectivity" play an important role in reinterpreting competing institutional pressures. Similarly, Reay and Hinings (2013) highlight how individual actors involved in the decision-making process can 'translate' higher level institutional pressures towards the members of the organization, in order to make practices meaningful and drive broader engagement with those practices (Canato et al., 2013; Van Grinsven et al., 2020).

Recent institutional theory studies assume that individuals' response to the complex demands of the external environment differs due to the individuals' ability to comprehend the environment and their motivation to act (Cholakova & Ravasi, 2020). While the first element refers to the individuals' knowledge about a certain institutional environment (Wry & York, 2017), the latter considers how individuals perceive the pressure in their environment (Toubiana & Ziestma, 2017; Voronov & Yorks, 2015). In their view, some actors embrace the opportunity given by the complex environment to do something novel for their organizations, while other actors struggle to accommodate any of the demands coming from various constituents (Cholakova & Ravasi, 2020).

Corporate governance scholars describe the perception of the directors' role as an important factor influencing the decision-making process. The classic board roles are based on fundamental theories in board studies: (1) the monitoring role (Boivie et al., 2016; Jensen & Meckling, 1976), (2) the resource provision role (Pfeffer & Salancik, 1978), (3) the strategic role

(Charan et al., 2014; Ingley & Van der Walt, 2001), and (4) the service role (Dalton et al., 1998). In addition, not-for-profit directors often describe their role as a representative role, focusing on being a voice for the stakeholder (Hillman et al., 2008). These studies pay attention to the specific interaction and board activities that directors perform based on their role in the decision-making process, but there is rather limited discussion on what is the focus of these board activities (Nicholson & Newton, 2010). A more recent study discusses the importance of understanding directors' implicit views of their roles, whom they serve and how they should act as a governing body (Boivie et al., 2021). Following this path of research, there is great interest in investigating directors' own interpretation of board roles and how this could influence the organizational decision-making process.

Scholars studying this relationship from the perspective of upper echelons theory mostly focus on connecting director attributes to organizational performance and the mediating mechanisms between the two of them (Hambrick, 2007; Liu et al., 2018). Most of these studies extensively examine CEO background characteristics and their influence on organizational strategic choices (Hambrick & Mason, 1984; Dezso & Ross, 2012). Studies in this stream of research also highlight the importance of accounting for the individuals cognition as a mediator between attributes and firm performance. This research often focuses on what the individuals know or how they process the information (Eggers & Kaplan, 2009; Daft & Weick, 1984). However, there is a limited understanding of how the individuals' attributes could influence organizational responses through the filter of cognitive processes (Liu et al., 2018).

In this study, we would like to address two challenges: (1) describing contributing factors to the directors' cognitive frames, and (2) studying the influence of the individuals' cognitive frames in developing organizational responses to institutional pressure. A cognitive frame can be

seen as "a mental template that individuals impose on an information environment to give it form and meaning" (Walsh, 1995, p. 281). To start, we examine the individual-level characteristics of the actors to study the role of their background and role definition in their cognitive frames (Goffman, 1974; Creed et al., 2002). We place less emphasis on the classic division of board roles, but rather allow directors to explain their own interpretation of the role and the most important aspects thereof.

Consequently, we turn our attention to the influence of these cognitive frames in developing organizational responses. According to prior studies, these cognitive frames could guide individuals to organize and interpret pressure rising in the organizational context (Weick, 1995; Dutton & Jackson, 1987), and, in turn, to develop managerial responses. For example, Hahn (2014) discusses how two frames can lead to differences in interpreting the organizational environment and different types of responses in corporate sustainability issues. However, we still know very little about how dominant the individuals' frames can be in developing organizational response to institutional pressure (Raaijmakers et al., 2015; Hahn et al., 2014). Therefore, we focus on the individuals' cognitive frames based on their background and role definition, and their organizational response to institutional pressure by using these cognitive frames. Thus, in this study, we pose the question: How are organizational responses to institutional pressure shaped by the individuals' cognitive frames?

Methods

We interviewed individuals serving as board members of different hospitals in the U.S. and the Netherlands to understand how decision- makers' cognitive frames mediate the responses of their organizations to institutional pressure. All the hospitals in our research setting faced the same pressure of implementing board evaluation practices. These governance practices are

recommended by health care governance institutions and accreditation agencies, or they are listed in the national health care governance code. There is an institutional pressure put on these hospitals to evolve their internal governance evaluation systems and to govern in a more transparent way by following standards described by these best practices.

Our setting is particularly useful for identifying the cognitive underpinnings of how organizations respond to institutional pressure, because while the hospitals were facing very similar regulative context in their own countries and similar normative context in both countries (see Table 1), the hospitals in our sample had reacted differently to the pressure of adopting best practices. By comparing how board members of hospitals that had adopted only statuary practices interpreted the institutional pressures with boards members of hospitals that had adopted the practices from the codes more extensively, we uncover how cognitive frames of decision-makers influence the responses of their organizations.

Table 1. Summary of the hospitals in our sample and the institutional environment in which they operated.

	U.S. hospitals	**Dutch hospitals**
Organizational form	Not-for-profit, not-teaching	Not-for-profit, not-teaching
Regulations binding service provision	Same federal regulations, similar state regulations	Same government regulations
Normative pressure on good governance	Governance institute for best practices provides the same information towards all U.S. hospitals	Industry-specific governance code binds all Dutch hospitals
Geographical location	Mix of urban and rural	Mix of urban and rural
Size	Belongs to top 10% in the area	Belongs to top 10% in the country

Data Collection

Between March and September in 2016, the first author conducted 30 in-depth retrospective interviews with board members of different U.S. and Dutch not-for-profit, non-teaching hospitals concerning the choices of best practices in their hospitals. We used a two-step sampling approach, where we first designed sampling criteria that minimized internal and external validity concerns and then approached board members that fulfilled these sampling criteria.

In designing the sampling criteria, we chose to select interviewees that (1) had been directly involved in making practice implementation decisions and (2) that had a formal position in the non-executive board of their hospitals (called board of directors in the U.S. and the supervisory board in the Netherlands). This ensured that our interviewees had a first-hand view and experience in making practice implementation decisions at their hospitals. In order to select interviewees whose profile was aligned with the broader hospital director population, we chose to interview (3) both male and female board members (forty percent of the respondents in our sample were female, which is aligned with the current gender diversity in hospital boards). Finally, we chose to interview board members that had (4) varying experience of serving on hospital boards (on average of 12-15 years' experience in our sample) and (5) varying occupational backgrounds. After designing these criteria, we approached board members in the U.S. and the Netherlands that met the criteria. We approached board members until 30 agreed to be interviewed (about 30% of the board members that we approached refused due to time constraints or lack of interest). See Table 2. for the background description of our selected interviewees.

---Insert Table 2 about here----

The interviews were semi-structured, using an interview guide with fifteen broad questions related to how the board members viewed the decision-making process concerning the adoption of best practices. The first author conducted the interviews face-to-face (18 interviews) and by phone (12 interviews). The interviews were recorded and transcribed verbatim, with one exception that we were unable to record. In this case, we took extensive notes and made detailed field notes shortly after the interview. The duration of the interviews varied between 40 and 90 minutes, and the average was 60 minutes. Appendix A provides an overview of the interview protocol. The semi-structured interview format was particularly useful for examining how individual decision-makers interpreted institutional pressures to be influencing the decision on developing an organizational response, as it allowed the interviewer to ask additional questions following revealing comments and issues, enhancing the trustworthiness of our data (Seidman, 2006).

Additional information was collected in February 2020 in order to have a more comprehensive overview of the board evaluation procedures and principles of the participating hospitals (see Table 3). Where there was insufficient information concerning the implementation of these procedures, we contacted the board members and board secretaries for additional information and explanation. Only two of the participating hospitals did not respond to our request. However, their website provided sufficient information on their choice of board evaluation. The decision to implement these new evaluation practices for participating hospitals began on average 6-12 months before the start of this study and the hospitals were still actively focused on them during the field research period.

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Data Analysis

Our analysis process can be described as an "iterative learning process" (Edmondson & McManus, 2007, p. 1156) where the interplay of data and theory generates a refined conceptual understanding of a phenomenon. We initially explored how our interviewees conceived board members' role in establishing best practice adoption decisions. Through this exploratory analysis we found, to our surprise, that though our sample comprised hospitals that were facing similar normative context, our interviewees held very different conceptions of the institutional pressure. This provided us with an opportunity to better understand and explain this variation in how board members interpret institutional pressures influencing the choices of their hospitals for good board practices. We subsequently analyzed our data in three steps, progressing from data-driven analysis of the cognitive frames that our interviewees relied on to make practice adoption decisions, to the development of an explanation as to why our interviewees conceived the institutional pressure on their hospitals very differently.

In the first part, we used the initial steps of the Gioia methodological approach for inductive code development. We started with open coding the transcripts to explore first-order concepts as described by the interviewees (Gioia et al., 2013). We looked at how the participants described good board governance and the organizational decisions relating to best practice choices in the broader organizational and institutional contexts (Creed et al., 2002). While some interviewees, for example, focused on the legal requirements as part of good board governance, others considered a broader variety of stakeholders' demands, when describing how their hospital has chosen to respond to the pressure of adopting board best practices. After the second round of data collection the focus has shifted to board evaluation practices. In this phase, there were very few quotes available; the data provided more specific information on the actual organizational choices regarding board evaluation. Therefore, most of the quotes in the manuscript will reflect on the

information collected in the first round. Using these first-order concepts we searched for commonalities and differences in the description of the participants' experience to create second-order themes. These identified themes focused on: (1) what stakeholder groups were the most important in terms of institutional pressure, (2) what are the participants' embodied values on good governance, and (3) what is their perspective on the timespan of board evaluation. After coding 26 interviews we found no new themes in the remaining 4 transcripts, reaching a point of theoretical saturation (Glaser & Strauss, 1967).

Following common steps of interpretive qualitative research (Myers, 2009), we then summarized in a matrix how board members interpreted the institutional pressures influencing practice adoption decisions based on the previously described themes (Hill et al., 1997). This matrix enabled us to identify and illustrate a connection between these three themes. Based on these connections we developed four empirically grounded cognitive frames that guided the directors to interpret their hospital's institutional environment and make board evaluation decisions: (1) Compliance-focused frame directs attention to regulations, (2) Community-focused frame emphasizes transparency, (3) Performance-focused frame takes organizational features into account, and (4) Multiple stakeholder-focused frame takes a comprehensive view. Table 4. below summarizes these frames and provides representative data grounding these frames.

In order to better understand why individuals embodied a particular cognitive frame, we analysed, in the second step of our analysis, how the professional background of individuals and their role in the board was linked with the cognitive frame they employed. To unpack the influence of their professional background, we studied our interviewees' occupational background, prior experience as a board member, and prior industry experience (see Table 5). In the findings section,

we provide a more detailed analysis of each of the four groups with representative data to support our claims.

Table 4. Cognitive frames that guided attention, embodied values and provided a timespan perspective to board members.

	Compliance- focused frame directs attention to regulations	**Community-focused frame emphasizes transparency**	**Performance-focused frame takes organizational features into account**	**Multiple stakeholder- focused frame takes a comprehensive view**
Conception of important stakeholder groups	Regulatory stakeholders providing legitimacy to hospital "Many government institutions have their own regulatory and organizational requirements, so it is important to meet a variety of their requirements." (NL29)	The community we serve "The directors work hard at making sure that they do their work in a proper way, but they are also respectful of the various communities they serve. We get our power from the people, not necessarily from the board. Whether we are effective or not, it comes from the people." (US3)	Only the key decision-makers "The board decides the "what" and the CEO decides the "how". We determine the long-term perspective and the CEO's role is to put this strategy into place. These decisions should be made within the boardroom." (US30)	All stakeholder groups important to the hospital "The board has to be transparent and accountable and holding and maintaining the public trust. It forcing us to collaborate with community partners and other stakeholders." (NL24)
Embodied values on good governance	Compliance and meeting the basic legal requirements "Hospitals are different from other not-for-profit boards and there are specific regulations they need to abide by. So [hospital governance] is about legal compliance and how laws and regulations should be implemented." (NL22)	Responding to the needs of the local community groups "Having some kind of context the community you are serving is very crucial." (US5)	Meeting long-term performance goals and objectives "We are talking about the long-term survival, the long-term sustainability of this hospital. This is my most important job as a supervisory board member." (NL29)	Involving strategically important stakeholder groups "People don't want to feel that decisions are made behind closed doors. You need to share the decisions and the rationale behind it with all relevant parties." (US30)
Timespan perspective	Meeting the legally required period for board evaluation "There is a self- evaluation for each board member, they are supposed to fill out once a three- year period. It goes up to the health system and the CEO and the Board Chairman review those each year."(US5)	Transparent evaluation with more set periods to review past performance "Both the annual CEO and the board evaluation results need to discussed by the entire board. We also introduced mid-term evaluations, to detect problems even earlier."(US16)	Evaluation with a purpose set to meet future organizational targets "Every evaluation has to have a clear purpose, otherwise why are we doing it. Match the questions to the priorities of the organization, instead of having a list of vague questions. It is about preparing for the future as well." (US6)	Evaluation as an ongoing process, looking at past performance and future goals "We look at the board as a whole, we look at the different committees, and they prepare a report for us. We look at the individual performance as well. As a Chair sometimes I do it in front of the board, sometimes I just call the person and share my opinion. It is an ongoing process. Evaluating each other should not create more tension, you are grown up, and you need to be able to take criticism."(NL21)

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In the third step of our analysis, we focused on developing theoretical explanations as to how the cognitive frames of board members influenced the choices that their respective hospitals had made as a response to the institutional pressure of adopting board evaluation practices. We used the findings from our earlier analyses to develop a model that illustrates how the directors' prior experience and role definition shaped their cognitive frames, and how these cognitive frames mediated the organizational choice of adopting best practice as a response to institutional pressure (see Figure 1). At the end of the analysis process, we assessed the generalizability of our findings, elaborated on the theoretical contributions of our study and provided possible avenues for future research (Eisenhardt, 1989).

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Findings

Our data shows that the hospitals in our research setting responded differently to the pressure to adopt board evaluation processes defined in the codes of good governance. While some hospitals had decided to only adopt the legally required evaluation practices (see hospitals 5,14,15 in Table 5), some had gone further and implemented the basic practices and processes defined by the codes of good governance (see hospitals 2-4, 6-8,13,16,19 in Table 5), and others, in turn used the codes to develop even more extensive evaluation practices (see hospitals 1, 9-12, 17,18 in Table 5).

Through our analysis, we found that differences in how the hospitals had chosen to respond to the pressure to adopt board evaluation practices were linked to the directors' cognitive frames. We discovered four qualitatively different cognitive frames: (1) Compliance-focused frame directs attention to regulations, (2) Community-focused frame emphasizes transparency, (3) Performance-

focused frame takes organizational features into account, and (4) Multiple stakeholder-focused frame takes a comprehensive view. In the following paragraphs, we use our qualitative data from both the U.S. and the Netherlands to illustrate the way in which the four frames hospital directors relied on, eventually conditioned their decision-making on best practice adoption. The majority of the quotes came from the first round of interviews, where the interview focus was on institutional pressure and organizational choices of adopting best practice. Many of the directors already mentioned board evaluation practices as an example for board practice adoption in the first data collection round, which are included in this manuscript. After the second round of data collection, there was the possibility to include additional quotes specifically on board evaluation.

Compliance-focused cognitive frame directs attention to regulations

The first cognitive frame invited directors to draw upon the regulations and expectations of the legal environment when it comes to selecting board evaluation practices. We asked the question: *What stakeholder groups were the most important in terms of institutional pressure?* Directors with this cognitive frame gave priority to regulatory stakeholders providing legitimacy to their hospitals over all other stakeholder groups. Directors with this frame were less inclined to implement additional evaluation practices, and emphasized instead, legal compliance and adopting the minimum evaluation practices in the most professional way. For example:

> Interviewer: *Could you please describe your current board evaluation practices?*
>
> *"Board members generally participate in the evaluation of the CEO, so the CEO gets evaluated at that level and those conversations are often very critical. This is a must before the new term appointment."(US2)*

"There is a self- evaluation for each board member, they are supposed to fill out once a three- year period. It goes up to the health system and the CEO and the Board Chairman review those each year."(US5)

Many American hospital directors with this frame only mentioned CEO evaluation and self-evaluation before new term appointment of the individual directors as it was a minimum requirement for their hospitals. On Dutch boards, collective board evaluation was required in addition to self-evaluation. Therefore, Dutch directors also described board performance evaluation as part of the requirements.

"We have a yearly evaluation, we evaluate the entire team. We also have an internal evaluation once a year with an external facilitator.[…] This is a requirement set by the health care accreditation agency to get some external check done. "(NL27)

If we examine their perspective on the timespan of the board evaluation, we can see that directors with this frame focused on the legally required evaluation types concerning the individuals/teams. They would like to see evaluation being done only in the officially prescribed time period like at the end of each year. This type of evaluation seems rather focused on evaluating past performance and often remains limited in its scope.

Prior experience. We found that directors with this cognitive frame commonly had only a few years experience as a director or limited work experience in the health care sector (or both). Our analysis suggested that these directors, many of whom had recently been elected to become a board member, had a limited understanding of the multiple institutional pressures influencing their hospitals. As such, the rules and frameworks created by regulative field constituents such as state and federal level government agencies provided these directors with a framework that enabled them to feel comfortable that they were focusing on the "right things" as board members.

Further, directors with long experience as members of boards of public and private organizations, but with no health care experience, fell into this category. They described the health care sector as a difficult industry to navigate in as a new board member. Our data did not support the view that the way these directors experienced the need to unconditionally comply with laws and regulations originated from their occupational background, as the occupational training of directors in this group varied (see Table 2).

Role definition. Board members relying on this frame conceived the role of the board as monitoring the process of adopting codes of good governance. They portrayed conforming with rules and regulations and keeping the board up-to-date about "best" practices as critical tasks of a board. They felt that stakeholders pressured them to comply with different rules and norms (rules, regulations, accreditation requirements, governance codes and best practices) defining "good" governance differently. One of the questions we asked reflected on their idea of good governance and best practices: *How do you define good governance and the role of governance codes in it?* While U.S. board members elaborated on several federal and state regulations that they need to comply with, for Dutch board members the health care governance code offered governance practices they needed to follow. For example:

"Good governance should mean that we think that all laws and regulations from this institution, as from national institution are fulfilled." (US9)

"Many government institutions have their own regulatory and organizational requirements, so you have to meet a variety of requirements." (NL27)

Community-focused cognitive frame emphasizes transparency

This cognitive frame places emphasis on the importance of transparent evaluation processes and the implementation of evaluation practices suggested by the code. This community-focused frame

reminded board members that they serve the local community and their work should be evaluated in a very transparent and elaborative way. Similar to the previous frame, the focus of directors is rather one-dimensional and does not allow much deviation from it. However, it does encourage more extensive evaluation practices than the minimum standards set by the previous cognitive frame. Directors relying on this frame either chose for implementing the evaluation practices as described by the code, or they actually exceeded the requirements by developing more advanced internal evaluation practices. One of the questions we asked focused on the changes in board evaluation practices over the years:

Interviewer: *Could you please describe any change that you experienced regarding board evaluation in the last years?*

"In the past, the governance committee did the CEO evaluation. Now we find it so important, that both the CEO and the board evaluation results need to discussed by the entire board. We also introduced mid-term evaluations, to detect problems even earlier."(US16)

On Dutch boards, directors with this frame described a wide variety of evaluation practices from supervisory board evaluation, to evaluating the relationship between the executive and supervisory board.

"We have done extensive evaluation of the board, the dynamics between the teams. We have also done self-evaluation with our question list, we have done both formal and informal evaluation."(NL25)

Directors with this frame often used board evaluation as a tool to show to the community stakeholder groups what they achieved and how they were performing in their positions. The evaluation also focused on past performance; however, it took a much more diverse scope on who should be evaluated and there were also some in-between evaluations. Their perspective on the

timespan of the evaluation is more flexible compared to directors with the previous frame; they aim for frequent or periodic evaluation to remain transparent about continuous board performance.

Prior experience. Our analysis suggested that the focus of these directors lay on meeting the norm of serving the community and that it originated from their affiliations with and roles in different community groups and organizations. The directors of U.S. hospitals had commonly served for lengthy periods as board members of other public organizations, and many of them also had considerable experience in the health care sector. Alternatively, the directors in Dutch hospitals who emphasized the importance of responding to the pressure coming from patients had a background in medicine. Many of the these directors in our study had a professional background in medicine or public administration (see Table 2).

Role definition. Board members using this frame highlighted their need to defend the interests that they are entrusted with by particular stakeholder groups, as decisions made in a hospital board will have implications for people beyond the hospital itself. The question we raised: *Who are the most important stakeholder groups in hospital board governance?* Board members of U.S. hospitals, for example, often portrayed themselves as guardians of the community:

"They work hard at making sure that they do their work in a proper way, but they also respectful of the various communities they serve. We get our power from the people, not necessarily from the board. Whether we are effective or not, it comes from the people." (US3)

Many of these directors enjoyed being in a close connection with the community. In the Netherlands, most directors referred to the patients as their most important stakeholder group. Especially the ones with a medical background felt that their role on the board was heavily influenced by their profession:

"I'm mostly responsible for patient quality and safety; representing patient's interest is the main area of my responsibilities." (NL25)

Performance-focused cognitive frame takes organizational features into account

This cognitive frame gave priorities to board evaluation practices that contributed to improving organizational performance. Rather than focusing on general evaluation, this frame required a well-thought out evaluation process reflecting the current and future situation of the hospital. As one board members quoted: *"The evaluation has to make sense." (NL23)* Since evaluation was considered part of meeting organizational and strategic goals, only key decision-makers and groups should make a decision on what and how it should be done. Directors with this frame often opted for following the evaluation practices as recommended by the code, as long as it evaluated performance of individuals or the board as a whole. They were mostly interested in the results of the evaluation process and how it could contribute to overall organizational performance.

Besides asking directors to list their current evaluation practices, we also asked them to describe: *What is the purpose of the board evaluation?* In the U.S., individual director evaluation was preferred among the directors, where the individuals contribution and engagement was evaluated by other directors and the directors themselves. In the Netherlands directors wanted to see a combination of individual and team evaluation, as they believed that contributions at both levels should be assessed for higher board performance.

"The self-evaluation part is pretty basic, but important. It is done internally with a facilitator and it is necessary for providing feedback on individual performance."(US29)

"Not completely 360, but we have evaluations and discussions with colleagues, so there is good evaluation for both executive and the non-executive positions, both at the individual and group level."(NL23)

"Every evaluation has to have a clear purpose, otherwise why are we doing it. Match the questions to the priorities of the organization, instead of having a list of vague questions." (US6)

Directors with this frame focused on finding the most suitable form of evaluation and used it as an important tool to critically examine meeting any current and future goals of the organization. From a timespan perspective of the evaluation, they believed in flexibility as to the evaluation should be conducted. The timing of the evaluation moments should be set in relation to specific organizational goals and objectives. In this group, the evaluation process was the most focused on the organizational goals and explicitly reflected on the current and future needs of the organization.

Prior experience. Our analysis suggested that those directors relying on this frame frequently had considerable experience as board members in both the public and private sector, but typically no experience in health care management. The majority of the directors had long-term management experience and they had acquired skills for dealing with different internal stakeholder groups through their previous work experience. They highlighted that when they started as a member of a new board, they focused on highlighting the key internal groups and defining what they expected from the board. The eleven directors who fell within this category had, on average, more than 15 years of experience as a board member and had different occupational backgrounds. Eight of these eleven directors had a business or accountancy background, while three had a background in medicine (see Table 2).

Role definition. This frame emphasized that the role of the board in the adoption of governance practices is distinct from the role of the executives. As directors reflected on their ideas of good governance, they highlighted that boards needed to engage in strategic decision-making, while the role of the executives was to execute the decisions made by the board. For example:

Interviewer: *How do you define good governance on the board?*

"The board decides the "what" and the CEO decides the "how". We determine the long-term strategy and the CEO's role is to put this strategy into place." (US29)

Instead of controlling the executives, board members (needed to) provide advice and support to executives to facilitate the adaptation of best practices to the needs of the local hospital. As such, they considered that having diversity in expertise within a board to be critical for well-rounded board governance.

"Now we clearly define also in the healthcare sector what kind of competencies we need in the supervisory board. We look for the person with variation of these competencies. So, I think that is a very big difference compared to ten years ago." (NL23)

"The best boards are diverse because of their expertise. A good board member who brings the expertise that does not exist on the board yet. That has a very positive influence on the dynamics." (US6)

Consistent with the overall focus on skills and competencies needed to adapt best practices to the local hospital, board members using this frame also found that their hospital's key stakeholders could provide critical input on the implementation process by providing different interpretations of the abstract governance codes. Compared to the previous frames, we can find some similarities with regards to the rather well-defined, one- dimensional focus of directors. However, the main difference lies in the perception of these best practices. While in Frame 1 and 2 the practice implementation is simply a tool to achieve a different goal, in Frame 3 the evaluation practice itself plays an important role and valued on its own.

Multiple stakeholder- focused cognitive frame takes a comprehensive view

The last cognitive frame has no pre-set priorities for certain stakeholder groups or organizational issues when we asked how they experience institutional pressure. From all the four cognitive frames, directors with this frame had the most comprehensive view on the organization and the use of best practices. Every topic and context individually decided on which pressure to respond to from the various stakeholder groups. This frame pushed directors to implement recommendations by the code as long as they were meeting the requirements of the organization. This frame encouraged the use of governance codes; however, it did not advocate for the one-size-fits-all situation. Hospital directors needed to select from best practices in order to complete an effective evaluation process. Directors relying on this frame preferred to work with the evaluation practices offered by the code and they were also open to developing additional internal practices themselves. They found it important that the evaluation addressed the issues the organization is facing at that specific moment, while it also involved the most relevant stakeholder groups in the decision-making process.

Interviewer: *Could you please describe any change that you experienced regarding board evaluation in the last years?*

"We have an evaluation now that must come from the codes, and for example 10 years ago this would not have happened. We look at the strategic objectives of the hospital and the team is evaluated based on that."(NL21)

For example, a Dutch director explained how meeting organizational objectives was a critical part of their current board evaluation system. An American director described a similar perspective, where both individual and group evaluations had a specific purpose, but codes of good governance were used as a starting point to establish the evaluation process.

"We look at the board as a whole, we look at the different committees, and they prepare a report for us. We look at the individual performance as well. As a Chair sometimes I do it in front of the board, sometimes I just call the person and share my opinion. Evaluating each other should not create more tension, you are grown up, and you need to be able to take criticism."(US30)

Compared to the previous frame, this frame was also focusing on specific organizational objectives and using evaluation as a tool to prepare for future scenarios. However, it took a more comprehensive view than just contributing to organizational performance. It used evaluation as a tool to manage the internal politics and dynamics of the board, while also keeping on an eye on the possible expectations of external stakeholder groups. From a timespan perspective, directors with this frame often had the mix of ongoing formal and informal evaluations and carefully selected the method that was the most suitable for the specific situation.

Prior experience. Our analysis suggested that the way these directors were able to describe and reflect on the complexities that the different demands of multiple field constituents created for making evaluation decisions originated from extensive board and industry experience. They had often served on different boards for many decades and had experience from both the public and private sectors (see Table 2). Many directors in this groups served as the chairs of their hospital boards. They described how they had obtained the knowledge and skills used for navigating between different institutional pressures throughout their extensive and diverse career. They also discussed how they now used the knowledge and skills they had by being able to prioritize these different demands and to respond to them in a timely fashion. For example:

Interviewer: *How do you define good governance on the board?*

"Being transparent and accountable and holding and maintaining the public trust. it forcing us to collaborate with community partners and other stakeholders you know. The board has to be the ambassador, the visionary leader and see it as an opportunity. our main responsibility

is that we are using public money and we really have to think how our margins and missions are aligned." (NL24)

Further, in this group our data did not support the view that the granular and deep understanding that these directors had developed about the institutional pressures influencing choices originate from their occupational background. Four directors belonging to this group had a public administration training, three had health care management background, and three interviewees had a background in higher education. Compared to the previous group, occupational background played a less important role, the emphasis being more on board experience in the perception of the directors.

Role definition. Board members with this frame suggested that relying solely on information provided by executives could be, in fact, very risky, and therefore found it important to have direct interaction with stakeholders such as groups of professionals working for the hospital:

"I really believe that you need to have access to the internal organization. By means of getting information and also focusing on the question 'do I hear what I hear and do I see what I see.' It is often a challenge for the supervisory board." (NL14)

"I think you should always communicate with other people and communities in the hospital. In order to get more informal and soft information. We always visit parts of the hospital and try to find a way to communicate with other people and other layers of the organization as well. We did this, so we are not completely dependent on the executive team for information." (US26)

Furthermore, board members considered that they are obliged to consult relevant external stakeholder groups when making decisions in the board and be transparent about the governance process in general. As one of the interviewees stated:

"Governance is listening to the whole organization, and giving people the platform that you think are important players in your organization. I try to be as approachable as possible. So, I know the Chairs of the Patient committee, the Quality committee, all those committees you have in the hospital. I meet them all regularly. I also ask them for advice, for example about selecting a new CEO." (NL21)

Discussion

The purpose of this study is to take a framing perspective for examining the individual directors' interpretation of the normative pressure to implement best practices in board evaluation, and to study how their cognitive frames influenced their response to this institutional pressure. We propose that the individual directors' cognitive frames influence the organizational responses in selecting board evaluation practices, and these cognitive frames are also shaped by the directors' prior experience and role definition (see Figure 1.). In the next sections, we discuss the contributions of our study more in detail.

Cognitive Perspective on Individuals Influencing Organizational Responses to Institutional Pressure

Cognitive frames of individuals. The first contribution of this study is to demonstrate how cognitive frames of individual decision-makers influence organizational responses to institutional pressure (Liu et al., 2018). While recent research has recognized the role that individuals play in interpreting institutional pressures and propelling them forward in organizations (Cholakova & Ravasi, 2020; Wry & York, 2017; Thornton et al., 2012), we show how the individuals' interpretation of institutional pressure can be embodied in cognitive frames, which eventually influenced their organizational responses. In this study, we have used the implementation of best

practices regarding board evaluation from codes of good governance as a normative pressure set by stakeholder groups to create a more transparent evaluation process.

We build on previous studies claiming that various cognitive frames actors infuse information with a certain meaning that leads to their choice of response to institutional pressure (Toubiana & Ziestma, 2017; Porac & Thomas, 2002; Weick, 1995). As a continuation, in our study, we show how directors use these cognitive frames to make sense of the institutional pressure and to connect it to developing organizational responses. We could identify four cognitive frames which direct the individual decision-makers toward one of the four ways of adopting board evaluation practices. Each cognitive frame provided directors with three dimensions in making sense of the institutional pressure: (1) conception of important stakeholder groups, (2) embodied values on good governance, and (3) timespan perspective. By using these dimensions, we can show how directors prioritize among the various stakeholder groups in the institutional environment when they face conflicting demands. We also describe how the embodied values on good governance related to a specific cognitive frame directs individuals in determining their response to institutional pressure. The individuals' embodied values on how governance should be exercised within their organizations is key to understanding their motivation to act and get involved when a certain issue arises in the institutional environment. We could also identify in the data that each cognitive frame is related to a certain timespan, which means that directors either apply a more time-restricted or a more forward-looking perspective when deciding on the organizational response.

We found, for example, how board members relying on the frame "Performance-focused cognitive frame takes organizational features into account" perceived the implementation of board evaluation practices as a tool to improve organizational performance. They would often like to

assess individual and team performance, while also utilizing the results of board evaluation in their strategic planning. Another example, where directors relying on the frame "Compliance-focused cognitive frame directs attention to regulations" perceive the board evaluation process as something that must be done at a pre-defined time period. They put the least effort into implementing new evaluation techniques - their focus being strictly on meeting the minimum requirements of the accreditation agency or the national health care governance code.

Individual factors contributing to cognitive frames. Our second contribution is that director's professional experience and the way they interpret their role amongst other decision-makers shape their interpretation of institutional pressure. This second finding contributes to studies that call for more nuanced understanding of the role of the individual characteristics in the individual actors' perception of the institutional environment (Cholakova & Ravasi, 2020; Besharov & Smith, 2014; Pache& Santos, 2013). These institutional theorists draw on research from cognitive psychology regarding the individuals' "representation of the individual environment" (Cholakova & Ravasi, 2020; Scott, 1969), and the complexity of their role identity (Campbell et al., 2003; Linville, 1985). They claim that individuals may respond to institutional complexity in various ways, by not just looking at their knowledge, but also their motivation to act. As our contribution, we examine the individual-level factors that contribute to the individuals' interpretation of the institutional environment in the form of cognitive frames. We develop a further understanding of what factors can influence the individuals' knowledge and motivation to act when facing institutional pressure. Firstly, we study the individual directors' board experience, professional background and health care experience to determine their ability to comprehend the institutional environment of their respective hospitals. Secondly, we study their role perception as a hospital director and how they describe good governance in the boardroom.

Prior experience. Previous research on studying the personal background in shaping cognitive frames focused on personality trait (McKenzie et al., 2009), tolerance for ambiguity (Furnham & Ribcherster, 1995) or "need for closure" (Webster & Kruglanski, 1994), when it comes to interpreting the institutional environment. In this study, we looked at the prior experience and role definition of the individual actors, and how the combination of these elements shape their cognitive frames. In order to understand the directors' knowledge of a given domain in a complex institutional environment (Wry & York, 2017; Thornton et.al, 2012), we studied the participants' professional background, health care industry and board experience. Extensive board experience serves as an important contributing factor to interpret the various demands of the internal and external constituents and how to prioritize them. In particular, having health care board experience was perceived by the board members as the most important factor in interpreting the environment. The participants claimed that the industry has such specific requirements and pressures put on the health care boards, that having experience in navigating in this industry will shape the decisions on how to respond to a certain pressure. Having board experience in different sectors does not necessarily help directors to successfully navigate in a complex health care environment. One of the more interesting findings is that professional background does not seem to play a major role in interpreting the institutional environment. None of the frames we identified can be directly connected to certain occupational groups or educational background.

Role perception. The second factor contributing to the individuals' cognitive frames is the perception of the directors' roles. We suggest that decision-makers' role in their social context and their "lived professional life" matter for the interpretation of the institutional environment. This finding is in line with the recent research investigating how important is to understand directors' implicit view of their roles (Boivie et al., 2021). The questions of whom they serve and how they

should act as a governing body provided an important guideline in exploring the connection between role perception and their cognitive frames. Directors with the "Compliance-focused frame" tend to perceive their role as a more classic, monitoring one with rather clear expectations (Boivie et al., 2016; Jensen & Meckling, 1976). Directors with the "Community-focused frame" mostly combine aspects of the resource provision role (Pfeffer & Salancik, 1978), the service role (Dalton et al., 1998) and the representative role (Hillman et al., 2008). The "Performance-focused frame" is mostly in line with the strategic role of directors and the long-term sustainability of the organization (Charan et al., 2014; Ingley & Van der Walt, 2001). It is interesting to see that the perception of directors with the last identified "Multiple-stakeholder focused frame" does not connect directly to any of the above discussed classic board roles. It takes elements of those roles, combines them, but also being able to switch between them. Compared to the previously described frames, directors with this frame have a more dynamic view of their role and they can adjust it as needed.

Limitations and Future Research

It is important to acknowledge the limitations of our study. We recognize that cognitive frames can be based on other rationales than those presented in this study (Zietsma & Vertinsky, 1999). We are aware that there are more elements that can shape these cognitive frames beyond the individual-level factors we addressed, which provides more avenues for future research into the role of individuals and their cognition in developing organizational responses. We also acknowledge the limitations of our sample, especially due to its small size and the issue of non-participating board members. In order to reduce the effects of this limitation, we designed sampling criteria that minimized internal and external validity concerns during the field research. We would also encourage scholars to apply different research methods (like surveys) to reach out to a larger

group of board members as a continuation of this study. We conducted this study in the health care industry, which could have specific requirements and dynamics to successfully respond to institutional pressure. We further acknowledge the limitation of not being able to collect much more specific data on board evaluation in the second round of data collection.

Finally, we believe that studying the cognitive frames of individual decision-makers and their role in developing organizational responses can provide further valuable insights into the development of managerial responses in other areas than governance practices within organizations. More research is required to shed light on how the individuals' cognitive frames might dominate team values and interpretation of a complex organizational issue, and eventually shape the team's decision-making process (Liu et al., 2018). Another relevant question for future research concerns further exploring the origins of frames and how various individual attributes (such as personality profiles or organizational tenure) can shape individuals' cognitive frames (Hahn et al., 2014). We encourage researchers to continue developing a greater understanding of the individual-level factors that can influence the individuals' interpretation of the institutional environment and how these factors contribute to managerial cognition on institutional pressure. Our research has documented the individual responses in a sector with very high institutional pressure to adopt best practices. Hence, a future line of research could examine the responses of decision-makers in sectors and countries, where this pressure is less significant or considered less important from the stakeholders' perspective.

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Appendix A. Selected questions from the Interview Protocol

1. What led you to become a board member?
2. How would you describe your role as a board member?
3. What are your main tasks on the board?
4. Would you give me a few characteristic qualities of what you would consider to be a valuable board member?
5. What channels do you use to learn about governance at your organization?
6. How would you define good board governance? What are the most important stakeholder groups in terms of institutional pressure?
7. How would you describe good board governance if you are looking at your team?
8. How would you describe good board governance if you are looking at the relationship between executive and non-executive directors?
9. How would you describe good board governance if you are looking at the relationship between the board and other stakeholder groups?
10. How do you describe good governance and the role of governance codes in it?
11. How are new practices or governance codes introduced to your board?
12. What do you consider important when choosing best practices do your organization?
13. Could you describe the process of choosing best practices for your board? Who is involved in the process and how is the decision made?
14. Could you describe your current board evaluation practices?
15. What is the purpose of board evaluation at your institution?
16. Could you describe any change that you observed regarding board evaluation?