Response to comments by referee 1

1. Confusion between teaching models and communication guidelines. Although we appreciate the solution the referee suggests of delaying the introduction of the term guideline until the discussion, we think there are compelling reasons for us to use the term from the start. We will explain these reasons below. Instead of delaying the use of this term we now explicate carefully in the introduction what is subsumed under the term guideline, in order to prevent confusion about the status or content of these documents.

- The theoretical framework of our study is the theory on implementation of guidelines. This necessitates describing the framework in the introduction, which implies defining the term guideline.
- The current paper is one in a series of papers on communication guidelines, of which the first one is in press and in which the same documents are used as the starting point for research. Uniformity of terminology will enhance coherence between the different papers and we are afraid that switching between model and guideline might add to rather than combat confusion.

Theoretically we consider our use of the term correct, for two reasons;
- We designated the documents that are at the centre of our studies as guidelines based on the definition of a guideline, published by the Dutch Institute for Healthcare Promotion (see methods).
- In the literature, the term ‘guideline’ is used for similar documents as those in our study; documents doing generic recommendations concerning communication or other aspects of healthcare. [1, 2]

Because of the importance of this point for the referee, we checked our interpretation of the word guideline by consulting two experts. We consulted prof. Richard Grol, head of the Centre for Quality of Care Research, Nijmegen University, Netherlands, expert in the field of medical guidelines and prof. Glyn Elwyn, Department of General Practice, Cardiff, Wales, specialised in doctor patient communication. They both agree with our use of the term guideline. Professor Grol remarked that the term ‘clinical practice guideline’ usually refers to recommendations concerning a specific disease, but that the term ‘guideline’ is also used for more generic recommendations. Professor Elwyn urged us to hold on to our use of the word guideline, because of the value of the associated implementation theory for doctor patient communication. With this support we decided to retain our use of the word guideline. We sincerely hope that our terminology will not be a ground to reject this paper.

2. Incorrect use of the term guideline because medical schools teach skills not performance
We have probably created confusion about this topic through our use of 'medical school'. The study was conducted within the centres for specialist training in general practice of the Dutch faculties of medicine. The objectives of postgraduate GP vocational training, including communication training, are formulated on the 'does' level of Miller's pyramid, i.e. the performance level, not the skills level. GP trainees are assessed on their performance of communication skills. In order to prevent confusion due to the common association of medical school with undergraduate medical education, we have replaced "medical school" with "GP training centre".

3. Sloppy use of literature.
In the literature, documents containing recommendations for doctor patient communication are referred to as models, frameworks, guides or guidelines (refs). For the sake of clarity and consistency in our paper, we use the term guideline with reference to all of these. For a comprehensive review of the literature, we included all the literature referring to these four terms. However, we agree with the referee that this might confuse readers when interpreting our references. We therefore explicitly state our definition of a communication guideline in the introduction and draw attention to the fact that other terms are used in the cited literature with reference to the same concept.

4. Patient involvement
We agree that it is of prime importance that patients should be involved in developing new communication guidelines. The reason we did not seek patients' opinions in this study is that the focus of this study is on the feasibility of guideline use by doctors. Obviously, by doing so we pursued a limited point of view, which will have to be expanded with different perspectives in future studies, notably that of the patient.

Response to reviewer 2

1. Description of stimulus material
We have added a more extensive description of the four guidelines in appendix 2.

2, 4, 5. Evaluate users complaints, in the light of existing theory (2), the content and context of the guideline (4) and actual implementation (5) and match your recommendations with the results of this evaluation.
We have described the content and context of the guidelines more extensively in appendices 1 and 2. We have given more depth to the discussion by evaluating the facilitating and impeding characteristics in the light of both implementation theory and theory on shared decision making, taking into account the content and context of the guidelines. We have compared users' statements with actual guideline use as found in earlier studies in Dutch GP-training. We based our recommendations on the conclusions of the total of this evaluation process.

3. Pay more attention to the tension between 'doctor knows best' and patient centredness in your results.
We have added to our discussion an evaluation of the ambivalence of doctors in their preference for shared decision making, which conflicts with their wish to stay in control.