PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Using the Power Wheel as a transformative tool to promote equity through spaces and places of patient engagement
AUTHORS	Sayani, Ambreen; Cordeaux, Emily; Wu, Kelly; Awil, Fatah; Garcia, Victoria; Hinds, Ryan; Jeji, Tara; Khan, Omar; Soh, Bee-Lee; Mensah, Desiree; Monteith, Linda; Musawi, Mursal; Rathbone, Marlene; Robinson, Jill; Sterling, Staceyan; Wardak, Dean; Amsdr, Isra; Khawari, Mohadessa; Niwe, Salva; Hussain, Azmina; Forster, Victoria; Maybee, Alies

VERSION 1 – REVIEW

REVIEWER	Lachman, Peter Royal College of Physicians of Ireland, Quality
REVIEW RETURNED	17-Oct-2023

GENERAL COMMENTS	Thank you for this paper which addresses the important issue of power in healthcare. The conceptual model is interesting though I think you need to consider it within an international context which is the journal readership. You present a model to assess power in patient engagement. I understand this is the terminology in Canada though if you want to extend your model to an international audience you will need to consider how language is an indication of power. For example once one becomes a patient one loses power. There is a move to call “the people known as patients” as people or persons. Therefore Person Centred Care (PCC) is used rather than Patient Centred care. The Beryl Institute https://theberylinstitute.org/ calls PCC Human Centre Care. Once does this the power differential in language is altered and the engagement is between people not patients seeking agency and a provider granting agency. If one considers the coproduction approach then patient engagement is only halfway up the coproduction ladder (https://www.thinklocalactpersonal.org.uk/Latest/Co-production-The-ladder-of-co-production) though that is not your intent as I think the power wheel aims to facilitate co-design and coproduction. There is growing literature on coproduction that you have not referenced or contextualised the wheel as a tool to use to coproduce and co-design. Look at https://academic.oup.com/intqhc/issue/33/Supplement_2 and shared decision making which is all about power sharing in the

	clinical setting. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making When introducing a new conceptual model consider what has been published in a similar vein e.g. https://nam.edu/programs/value-science-driven-health-care/achieving-health-equity-and-systems-transformation-through-community-engagement-a-conceptual-model/ and https://doi.org/10.31478/202202c . Has the development of the Wheel been an exercise in coproduction with people who receive care? How was it tested? I would like more on how the wheel is used. This section requires revision. Perhaps a case study can make that clearer. How are people trained to use the tool? How are the people we know as patients involved and how do you measure whether it works? Finally you refer to tools made available and all I can see is the one tool – are there more available? Overall an interesting paper but needs to move from your programme to one that is applicable to other contexts and within current thinking in coproduction and equity literature. E.g. if you demonstrate how the Power Wheel can be used within coproduction and shared decision making as a reflective tool then it may be adopted more readily

REVIEWER	Martin-Payo, Ruben Universidad de Oviedo, Meicina
REVIEW RETURNED	02-Nov-2023

GENERAL COMMENTS	Thanks for giving me the opportunity to review this paper. The authors try to a new tool, the Power Wheel, defined as “a tool that can be used to interrogate power relations in patient engagement, and promote learning, reflection, and transformative action so that places and spaces of patient engagement can become more inclusive of, and accessible to, diverse patient partners with a goal of improving health equity”. Without doubt it could be a useful tool according to the needs of the population. The paper is well written but I suggest to include some modifications. 1. I recommend to include a paragraph specifically to describe the aim of the paper. 2. The authors define the Power Wheel as an adaptation of the power cube. In my opinion, it’s essential to include a brief description of the power cube and clarify readers what the Power Wheel ads. In this sense, I think that also could be useful to include previous models, developed for similar purposes than Power Wheel, to justify the need of the new tool. 3. The Power Wheel consists of three dimensions. I consider that is essential to explain the relationship between the dimensions. It could help to understand the tool and to improve its usability.

REVIEWER	Bailey, Julia

	University College London, Primary Care and Population Health
REVIEW RETURNED	12-Nov-2023

GENERAL COMMENTS	This paper is well written (clear and engaging), and could be an important contribution to how to meaningfully involve patients and the public in research, intervention design and policy through addressing power imbalances. The paper describes mechanisms of power imbalance and why it is important to address these for meaningful collaborations with patients and the public, but does not discuss how to actually do this - "We have co-designed a Power Wheel to illuminate opportunities for transformation and social inclusion within the spaces and places of patient engagement so that they are oriented towards a goal of improving health equity." It would be good to include much more detail on how the wheel is used in practice, answering the questions raised in the text: How can we engage with diverse partners? Why is it so challenging to maintain engagement? How can you engage meaningfully within the confines of external structures? "Conceptual tools may do little to challenge the social and structural inequities that underpin experiences of trauma, oppression and discrimination within patient engagement settings". - this element is not discussed - this is presumably a limitation of the use of the power wheel Please include details on the social positionally of the co-author team. For international readers, please explain more about what the Quintuple Aim is. Useful explanations of different types of power dynamic. Power wheel (figure 1). Useful ways of conceptualising power dynamics, although a left to right scale of involvement and power sharing might make more sense visually. The labels and definitions for Space and Place are quite confusing, since these seem to be overlapping. More conceptual clarity is needed for this to be a useful tool. Place - policy does not belong in micro I would think, unless it is 'policy development'? Summary: This paper could be a really useful contribution to the field by explaining how the power wheel was actually used in practice, with discussion of the strengths and limitations of its use.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1 comments:
1. The conceptual model is interesting though I think you need to consider it within an international context which is the journal readership.

You present a model to assess power in patient engagement. I understand this is the terminology in Canada though if you want to extend your model to an international audience you will need to consider how language is an indication of power.

For example once one becomes a patient one loses power. There is a move to call "the people known as patients" as people or persons. Therefore Person Centred Care (PCC) is used rather than Patient Centred care. The Beryl Institute https://theberylinstitute.org/ calls PCC Human Centre Care. Once does this the power differential in language is altered and the engagement is between people not patients seeking agency and a provider granting agency.

If one considers the coproduction approach then patient engagement is only halfway up the coproduction ladder (https://www.thinklocalactpersonal.org.uk/Latest/Co-production-The-ladder-of-co-production) though that is not your intent as I think the power wheel aims to facilitate co-design and coproduction.
Thank you very much for this thoughtful comment on the use of the word "patient". We agree that language is complex and terms such as "patient" can reproduce unequal power relations. We have updated the text to reflect that we are using the term "patient partner" as it is the language used by the Canadian Institutes of Health Research, the Canadian federal health funding agency. We have added a sentence to indicate this and have added that while important, discussing the limitations of the terms used to describe patient partnership roles are out of scope for this paper.

2. There is growing literature on coproduction that you have not referenced or contextualised the wheel as a tool to use to coproduce and co-design. Look at https://academic.oup.com/intqhc/issue/33/Supplement_2 and shared decision making which is all about power sharing in the clinical setting. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making
When introducing a new conceptual model consider what has been published in a similar vein e.g. https://nam.edu/programs/value-science-driven-health-care/achieving-health-equity-and-systems-transformation-through-community-engagement-a-conceptual-model/
and https://doi.org/10.31478/202202c .
Thank you for sharing these resources with us. We have added the following sentence and referenced studies and frameworks on co-production including one that you have shared with us: "While we acknowledge the growing number of studies and frameworks on co-production in healthcare policy and research, their remains a dearth of literature on power relations in patient engagement – particularly as it relates to partnering with diverse individuals and equitable involvement in decision-making."

3. Has the development of the Wheel been an exercise in coproduction with people who receive care? How was it tested?
Thank you for this question. We have added more detail on how the Power Wheel has been codesigned by EMPaCT members. Additionally, we have included more information about the codesign of EMPaCT, as it is within our monthly meetings as a group that we have come to collectively identify power relations as a key barrier to equity-oriented patient engagement.

We have updated the section on EMPaCT to reflect the following:
"EMPaCT was co-initiated in 2020 by a patient partner (Alies Maybee) and scientific partner (Ambreen Sayani). Since then, our community table has organically grown and currently comprises 20 members. These include 14 patient partners, (Alies Maybee, Isra Amsdr, Fatah Awil, Tara Jeji, Omar Khan, Mohaddesa Khawari, Bee Lee, Desiree Mensah, Linda Monteith, Mursal Musawi, Jill Robinson, Staceyan Sterling, Dean Wardak, Victoria Garcia) who represent a diversity of intersectional social identities; two community partners, defined as individuals who volunteer their

time to support community outreach and engagement (Ryan Hinds, Kelly Wu); three academic trainees, defined as individuals who work under supervision to enhance their research and patient engagement skills (Emily Cordeaux, Salva Niwe, Azmina Hussain); and a scientific lead, responsible for leading the intellectual direction of proposed activities and coordinating the financial and administrative aspects of grants and awards (Ambreen Sayani). This paper stems from over 30 years of collective experience as patient partners involved across the healthcare ecosystem (including patient partner, Victoria Forster who is also a scientist) and the experience of health system partners with experience engaging diverse communities (Cordeaux, Wu, Niwe, Hinds, Hussain and Sayani). Sayani is a health system leader, physician and critical social scientist, who studies inclusive patient engagement and health equity. We are all co-authors on this paper."

4. I would like more on how the wheel is used. This section requires revision. Perhaps a case study can make that clearer. How are people trained to use the tool? How are the people we know as patients involved and how do you measure whether it works?
Thank you for this recommendation. We have updated the section: "Using the Power Wheel to analyse power in places and spaces of patient engagement" to clarify how researchers, clinicians and decision-makers can use the Power Wheel to interrogate power within their projects or teams and create opportunities for decision-making for diverse patient partners. This includes adding self-reflective prompts that readers can reflect on when using the Power Wheel to interrogate power in the places and spaces of their patient engagement practices:
1. In what place(s) is your patient engagement work occurring?
2. Are these space(s) closed, open, or created?
3. What level of influence do patient partners have?
4. How could these factors influence the diversity of patient partners you are engaging?
5. How could your patient engagement practices be modified so that they are more inclusive?

We have additionally added the following sentence to clarify that a comprehensive case study is forthcoming:

"We are using the Power Wheel to conduct a case study of power relations in different models of patient engagement and implications for decision-making among diverse patient partners. This work is forthcoming."

5. Finally you refer to tools made available and all I can see is the one tool – are there more available?

We have updated this phrasing so that it reads as "tool" instead of "tools" as we are referring to the Power Wheel.

Overall an interesting paper but needs to move from your programme to one that is applicable to other contexts and within current thinking in coproduction and equity literature.
E.g. if you demonstrate how the Power Wheel can be used within coproduction and shared decision making as a reflective tool then it may be adopted more readily

Reviewer 2 comments:
1. I recommend to include a paragraph specifically to describe the aim of the paper.
Thank you for this comment. We have revised our Introduction so that the aims of the paper are explicit.

2. The authors define the Power Wheel as an adaptation of the power cube. In my opinion, it's essential to include a brief description of the power cube and clarify readers what the Power Wheel

ads. In this sense, I think that also could be useful to include previous models, developed for similar purposes than Power Wheel, to justify the need of the new tool.
We have added a sentence to our description of the Power Cube to clarify the key components: “When considered together, these elements take the shape of a Power Cube – a framework which facilitates analysis of the dimensions of space, level and forms of power, and the interrelationship between each.”
We have additionally revised the following section: “The issue: Exclusionary practices and the need for inclusive patient engagement” to increase clarity for readers on the need for conceptual tools to unpack and understand power relations in the places and spaces of patient engagement if we wish to engage more diversely.
We have added the following sentence and referenced studies and frameworks on co-production to make explicit the need for a new conceptual tool:
“While we acknowledge the growing number of studies and frameworks on co-production in healthcare policy and research, their remains a dearth of literature on power relations in patient engagement – particularly as it relates to partnering with diverse individuals and equitable involvement in decision-making.”

3. The Power Wheel consists of three dimensions. I consider that is essential to explain the relationship between the dimensions. It could help to understand the tool and to improve its usability.
Thank you. We have clarified the relationship between each in a summary sentence, “In summary, place determines which level of decision-making is open for discussion; space determines the social relationships between people that shape conversations around decision-making; and finally influence, is the degree to which decision-making is shared towards a common goal”.
Reviewer 3 comments:
1. The paper describes mechanisms of power imbalance and why it is important to address these for meaningful collaborations with patients and the public, but does not discuss how to actually do this -

"We have co-designed a Power Wheel to illuminate opportunities for transformation and social inclusion within the spaces and places of patient engagement so that they are oriented towards a goal of improving health equity."

Thank you for this comment. As noted above in response to Reviewer 1’s comments, we have updated the section: “Using the Power Wheel to analyse power in places and spaces of patient engagement” to clarify how researchers, clinicians and decision-makers can use the Power Wheel to interrogate power within their projects or teams and create opportunities for decision-making for diverse patient partners. This includes adding self-reflective prompts that readers can reflect on when using the Power Wheel to interrogate power in the places and spaces of their patient engagement practices.

2. It would be good to include much more detail on how the wheel is used in practice, answering the questions raised in the text: How can we engage with diverse partners? Why is it so challenging to maintain engagement? How can you engage meaningfully within the confines of external structures?
Thank you for raising this comment. We have re-positioned these questions as reflective prompts to be used with the Power Wheel.
3. "Conceptual tools may do little to challenge the social and structural inequities that underpin experiences of trauma, oppression and discrimination within patient engagement settings". - this element is not discussed - this is presumably a limitation of the use of the power wheel
We have removed the section on Strengths and limitations which includes this statement as it is not for the Communication article format.
4. Please include details on the social positionally of the co-author team.
We have added more information on the social positionality of co-authors in the section on EMPaCT:

“EMPaCT was co-initiated in 2020 by a patient partner (Alies Maybee) and scientific partner (Ambreen Sayani). Since then, our community table has organically grown and currently comprises 20 members. These include 14 patient partners, (Alies Maybee, Isra Amsdr, Fatah Awil, Tara Jeji, Omar Khan, Mohaddesa Khawari, Bee Lee, Desiree Mensah, Linda Monteith, Mursal Musawi, Jill Robinson, Staceyan Sterling, Dean Wardak, Victoria Garcia) who represent a diversity of intersectional social identities; two community partners, defined as individuals who volunteer their time to support community outreach and engagement (Ryan Hinds, Kelly Wu); three academic trainees, defined as individuals who work under supervision to enhance their research and patient engagement skills (Emily Cordeaux, Salva Niwe, Azmina Hussain); and a scientific lead, responsible for leading the intellectual direction of proposed activities and coordinating the financial and administrative aspects of grants and awards (Ambreen Sayani). This paper stems from over 30 years of collective experience as patient partners involved across the healthcare ecosystem (including patient partner, Victoria Forster who is also a scientist) and the experience of health system partners with experience engaging diverse communities (Cordeaux, Wu, Niwe, Hinds, Hussain and Sayani). Sayani is a health system leader, physician and critical social scientist, who studies inclusive patient engagement and health equity. We are all co-authors on this paper..”
5. For international readers, please explain more about what the Quintuple Aim is.
Thank you, we have updated the text to read: “Health systems are increasingly recognizing the importance of actively involving patients in decision-making to achieve the Quintuple Aim, the Institute of Healthcare Improvement’s framework for improving patient experience, population health, work-life of healthcare providers, reducing costs, and promoting equity.”
6. Useful explanations of different types of power dynamic.

Power wheel (figure 1).
Useful ways of conceptualising power dynamics, although a left to right scale of involvement and power sharing might make more sense visually. The labels and definitions for Space and Place are quite confusing, since these seem to be overlapping. More conceptual clarity is needed for this to be a useful tool.
Thank you very much for this observation. We have updated the Space and Place definitions to provide greater conceptual clarity :
“Places are socially constructed areas that have acquired meaning through human activities and interactions – and are areas where social, political and economic power are held. Places of patient engagement occur at the micro level, such as a healthcare system project that is the reason for patient engagement; the meso level, institutions where patient engagement occurs and the macro level, the jurisdictional levels at which health and social system decisions are made which impact patient engagement. The place of a patient engagement activity directs the levels where agents can exert influence, with each level interrelated to the others. Space refers to an abstract or physical setting where social interactions and relationships occur. Social and cultural forces determine the dimensions of space and can take three forms: closed, where decision-making occurs without patient engagement; invited, where patient partners are invited into healthcare spaces to contribute their perspectives on a predetermined topic or area of study; and created, informal or formal places where patient partners come together around a common need, and create their own boundaries around priorities, policies, and programs.”
We would like to emphasise that the Power Wheel was co-designed with community and with the help of a graphic artist so that we could capture the non-linear relationship between each dimension. A wheel was the best way to convey the interrelationships between dimensions.

7. Place - policy does not belong in micro I would think, unless it is 'policy development'?
Thank you – we have updated the table so that it states “policy development” instead of “policy.

Summary: This paper could be a really useful contribution to the field by explaining how the power wheel was actually used in practice, with discussion of the strengths and limitations of its use.

Thank you very much to the reviewers for their thoughtful comments which have strengthened our paper. Please let us know if you require further information or clarification. We are very happy to answer any questions you or the reviewers may have.

VERSION 2 – REVIEW

REVIEWER	Lachman, Peter Royal College of Physicians of Ireland, Quality
REVIEW RETURNED	18-Dec-2023

GENERAL COMMENTS	In some ways the paper has improved as the authors have addressed some of the initial concerns, However in doing so they have made the paper very difficult to read. I compared this draft to the first draft and it is now hard to navigate and I still do not understand how to use the Power Wheel in practice. And there is no evidence that it actually works other than descriptive. Perhaps this is because of the style of writing rather than content. The average reader will find the paper complex and not easy to understand. With careful editing, the authors could make this an interesting paper to read. In response to the critique by the three reviewers the authors have added many explanations and names in parenthesise, with long sentences that are difficult to follow,. I recommend the following 1. The Introduction should give the background to the problem – i.e. how do we address the issue of power in engaging or coproducing with the people called patients when we engage them, in particular people from vulnerable or marginalised communities. 2. All items in parentheses must be removed and explained in the terminology table. Make it simple and define the problem clearly with shorter paragraphs and sentences. 3. Describe the programme Equity Mobilizing Partnerships in Community (EMPaCT (take out award winning etc). We do not need the names of people involved just their roles. Describe what it does and its impact – how do you know it has worked? (Query EMPaCT has been running for 3 years; you also say over 30 years of collective experience – is that adding the years of each member of the programme?) 4. A description of the development of the Power Tool and how it has made a difference- a case study illustrating its use would be useful. 5. Guide on how the Power Tool can be used by the reader. 6. Terminology can be addressed by adding a table which defines the terms. The glossary of terms would be included here. Items to include are Quintuple aim, Patient partner, Health Service Partner etc. This will enable the authors to remove the jargon in the paper. 7. At the end acknowledge the people involved - not in the text of the paper. I understand that the authors understand their message; perhaps they need to stand back and ask will others understand the message? My understanding is

	- Power is a problem in patient engagement - EMPaCT is a programme developed to challenge the current paradigm of patient engagement and to facilitate the active involvement of marginalised people in engagement - The Power Wheel is a tool that can be used to address this problem - Readers can use the tool in this way…. And the abstract needs to be more succinct. I think there is a paper to share but not in this format. I could assist and edit paper if I had a word version.

REVIEWER	Bailey, Julia University College London, Primary Care and Population Health
REVIEW RETURNED	06-Jan-2024

GENERAL COMMENTS	This is a well written and interesting paper offering theoretical insight practical utility for teams wishing to engage people/patients in healthcare decision-making. I recommend some further small revisions: Abstract: The abstract does not reflect the richness of the paper's contents and should be rewritten to illustrate the theoretical insights and utility of the Power Wheel tool. Some sentences should be shortened for clarity. Spaces can never be completely 'safe' but can be safer - I suggest revising this, including reference/s. The final section needs more linkage to wider literature. For example, references are needed in support of these statements: 'The opposite of this, designing care with and for only people with privilege can perpetuate the status quo, further marginalizing groups that have been excluded, and amplify harms and inequities'; and 'only by accruing power back to individuals from structurally seldom-heard communities that we can begin to advance equity'. Well done.

VERSION 2 – AUTHOR RESPONSE

Reviewer 1 comments:

1. The Introduction should give the background to the problem – i.e. how do we address the issue of power in engaging or coproducing with the people called patients when we engage them, in particular people from vulnerable or marginalised communities.

Thank you for this feedback. We have revised the introduction to clearly highlight the need to address exclusionary patient engagement practices and introduce how addressing power relations in patient engagement can help accrue power to patient partners from structurally marginalized communities.

2. All items in parentheses must be removed and explained in the terminology table. Make it simple and define the problem clearly with shorter paragraphs and sentences.

Thank you for this feedback. We have removed items in parentheses and added a glossary of terms to a table.

3. Describe the programme Equity Mobilizing Partnerships in Community (EMPaCT (take out award winning etc). We do not need the names of people involved just their roles. Describe what it does and its impact – how do you know it has worked? (Query EMPaCT has been running for 3 years; you also say over 30 years of collective experience – is that adding the years of each member of the programme?)

We have revised our description of EMPaCT in section “Learning from an innovation in equity-promoting patient engagement: EMPaCT” so that it is more succinct. In this revision we have included the principles for equity-promoting patient engagement that underpin the EMPaCT model of engagement and how we came to identify as a group asymmetric power relations as a key barrier to equity-oriented patient engagement.

We have clarified in the text that collectively we have 30 years of collective experience as patient partners engaged across the healthcare ecosystem. We have included this to speak to the many years of collective experience within our group.

4. A description of the development of the Power Tool and how it has made a difference- a case study illustrating its use would be useful.

We have included in the text of the manuscript and demonstrated through figures how the Power Wheel can be used to analyse power in places of spaces of patient engagement using two project examples. We have kept in the text mention that we are conducting a case study of power relations in different models of patient engagement and that this work is forthcoming.

Updated text:

The Power Wheel can be used to analyse the interspersion of power in places and spaces of patient engagement. For example, in Figure 2, power is distributed at a micro-level, invited-space that is open for consultation-level influence. This wheel can exemplify a variety of institutional patient engagement activities that have localized impact – such as a quality improvement project in a specific department. In Figure 3, power is distributed more broadly – with macro-level, collaborative decision-making, in a created space that was decided by patient partners. The wheel in Figure 3 is an example of a project where EMPaCT was engaged in national-level policymaking. As a community-table, EMPaCT is unique because members of EMPaCT decide which projects they want to engage with – and ultimately the engagement determines the degree of influence EMPaCT has on the outcomes of the project. Thus, EMPaCT always exerts multiple levels of influence, both determined by its novel model of patient engagement and the level of decision-making power available through a health system partner's project. We are conducting a case study of power relations in different models of patient engagement using the Power Wheel. This work is forthcoming.

5. Guide on how the Power Tool can be used by the reader.

Thank you for this recommendation. We have updated the section: "Using the Power Wheel to transform places and spaces of patient engagement" to clarify how researchers, clinicians and decision-makers can use the Power Wheel to interrogate power within their projects or teams and create opportunities for decision-making for diverse patient partners.

Updated text:

The Power Wheel is an action-oriented tool that supports better praxis in equity-promoting patient engagement. Researchers, clinicians and decision-makers in health systems can use the Power Wheel as a **reporting tool** to share their patient engagement practices**,** as a **reflective tool** to analyse the various dimensions of power within their patient engagement practices and as a **transformative tool** to identify tangible actions to modify spaces and places of patient engagement so they become more equitable in alignment with the goals of the Quintuple Aim.

We recommend using the Power Wheel to **report**, **reflect**, and **resolve** power asymmetries within patient engagement practices in the following ways:

Report: The current status of decision-making influence within a given patient engagement project can be reported as a figure in the methods section of presentations, reports and publications to promote transparency and accountability in patient engagement practices. We have given examples in Figure 2 and 3, and recommend that this becomes a component of regular reporting for all projects that include patient partners.

2. **Reflect**: The spaces and places of patient engagement within a given project can be analysed to question which perspectives are privileged in decision-making and which are absent. The diversity jigsaw is an activity that can be completed individually or as a group alongside the Power Wheel to unpack which identities, such as race, gender, class, sexual orientation, disability, etc. are currently included/ excluded and how issues of power asymmetry may be contributing to participation.
3. **Resolve**: The opportunities to transform power asymmetries can be identified and existing skills, knowledge, relationships and resources mobilized to promote health equity. This can be done using a strengths-based, relationship-driven approach to addressing challenges, fostering collaboration, and promoting inclusivity known as asset mapping.

6. Terminology can be addressed by adding a table which defines the terms. The glossary of terms would be included here. Items to include are Quintuple aim, Patient partner, Health Service Partner etc. This will enable the authors to remove the jargon in the paper.

Thank you – we have added a glossary of terms to a table and removed definitions from the body of the manuscript.

7. At the end acknowledge the people involved - not in the text of the paper.

We have removed the list of EMPaCT members from the manuscript text.

Reviewer 2 comments:

1. Abstract: The abstract does not reflect the richness of the paper's contents and should be rewritten to illustrate the theoretical insights and utility of the Power Wheel tool. Some sentences should be shortened for clarity.

Thank you for this feedback. We have edited the abstract to reflect the following:

Patient engagement is the active collaboration between patient partners and health system partners towards a goal of making decisions that centre patient needs – thus improving experiences of care, and overall effectiveness of health services in alignment with the Quintuple Aim. An important but challenging aspect of patient engagement is including diverse perspectives. Specifically, populations that experience the most health inequities are also the most frequently marginalized from decision-making in policy, practice and research creating a healthcare ecosystem that reinforces structural marginalization and perpetuates health inequities. Despite the growing body of literature on knowledge co-production, few have addressed the role of power relations in patient engagement and offered actionable steps for engaging diverse patients in an inclusive way with a goal of improving health equity. To fill this knowledge gap, we draw on theoretical concepts of power, our own experience co-designing a novel model of patient engagement that is equity-promoting, Equity Mobilizing Partnerships in Community (EMPaCT), and over 30 years of collective experience as patient partners engaged across the healthcare ecosystem. We introduce readers to a new conceptual tool, the Power Wheel, that can be used to analyse the interspersion of power in the places and spaces of patient engagement. As a tool for ongoing praxis (reflection + action) the Power Wheel can be used to report, reflect and resolve power asymmetries in patient partnered projects, thereby increasing transparency and illuminating opportunities for equitable transformation and social inclusion so that health services can meet the needs and priorities of all people.

2. Spaces can never be completely 'safe' but can be safer - I suggest revising this, including reference/s.

Thank you for this thoughtful comment and we realise that this is often the experience of patient partners. Whenever we have used the term ‘safe spaces’, rather than ‘safer’ spaces it is directly language used by patient partners/ members who are co-authors on this manuscript to describe how they feel about EMPaCT.

3. The final section needs more linkage to wider literature. For example, references are needed in support of these statements: 'The opposite of this, designing care with and for only people with privilege can perpetuate the status quo, further marginalizing groups that have been excluded, and amplify harms and inequities'; and 'only by accruing power back to individuals from structurally seldom-heard communities that we can begin to advance equity'.

Thank you for this comment. We have edited the conclusion so that it focuses more tightly on – and does detract from – the Power Wheel. The opening sentence of the Conclusion is now clear that it is our opinion as a group that the practice of equity-oriented patient engagement is a pursuit of social justice.

VERSION 3 – REVIEW

REVIEWER	Lachman, Peter Royal College of Physicians of Ireland, Quality
REVIEW RETURNED	03-Feb-2024

GENERAL COMMENTS	Thank you for the revised version of the paper. It has been improved considerably. I presume this is a communication paper as per the guidelines for authors. I have marked up the text to show where you need to make changes. The main challenge for you is to bring the reader along with you so the flow needs to be simplified. Including a glossary of terms means you do not need to redefine in text - the aim is to make the jargon easy to understand for the reader I think the journal style does not allow hyperlinks in text as you have done or bold besides for headings - I have noted a few and you need to adjust throughout the text.

VERSION 3 – AUTHOR RESPONSE

1. Request to edit “30 years of collective experience as patient partners” to extensive experience

Thank you, we have updated the manuscript so that it reads “extensive experience as patient partners engaged across the healthcare ecosystem”.

2. Need to define Quintuple aim as is jargon and not in the glossary

We have added Quintuple Aim to the glossary of terms.

3. Define diverse in the glossary of terms and not in the text. Add other jargon to glossary of terms e.g., structurally marginalized etc.

We have added diverse and structurally marginalized to the glossary of terms.

4. Remove italics and bold text

Thank you, we have removed all bolding in the text (except for section headers to denote a

header). Neil Bennet kindly confirmed by email that italics are allowed for text emphasis.

5. Check if hyperlinks are allowed by journal guidelines

We have removed hyperlinks to adhere with journal guidelines.

6. This paragraph (description of dimensions of Power Wheel) would be clearer as a table with the text referencing the table

We have included the contents of this paragraph in the glossary of terms table.

7. Figure 2 should appear here (in paragraph that describes dimensions of Power Wheel) and figure 3 just after reference to figure 3.

We have moved the figure as suggested.

8. Perhaps the glossary of terms would be Table 1 and appear early on in the paper and not at the end.

Thank you for this recommendation. We have moved the glossary of terms up in the paper and reordered the terms in alphabetical order.