Suffering. The very word made doctors uncomfortable. Medical journals avoided it, instructing authors to say that patients “‘have’ a disease or complications or side effects rather than ‘suffer’ or ‘suffer from’ them,” said Dr. Thomas H. Lee, the chief medical officer of Press Ganey, a company that surveys hospital patients.

But now, reducing patient suffering — the kind caused not by disease but by medical care itself — has become a medical goal. The effort is driven partly by competition and partly by a realization that suffering, whether from long waits, inadequate explanations or feeling lost in the shuffle, is a real and pressing issue. It is as important, says Dr. Kenneth Sands, the chief quality officer at Harvard’s Beth Israel Deaconess Medical Center in Boston, as injuries, like medication errors or falls, or infections acquired in a hospital.

The problem is how to measure it and what to do about it.

Dr. Sands and his colleagues decided to start by asking their own patients what made them suffer.

They found several categories. Communications — for example, a doctor blurting out, “Oh, it looks like you have cancer.” Or losing a valuable, like a wedding ring. Or loss of privacy — a doctor discussing a patient’s medical condition where an adjacent patient could hear.

“These are harms,” Dr. Sands said. “They elicit suffering. They can be long lasting, and they currently are largely unquantified, uncounted, unrecorded.”

One way to quantify these harms is to observe and note them, which is part of what Beth Israel Deaconess is doing. Another is to supplement efforts with patient surveys. Patient surveys, of course, have been around for decades. And since 2007, Medicare has required short surveys after discharge.

But patient surveys were usually not used by hospitals to measure suffering.
Now they are. And even when a survey question does not directly ask about suffering, sharp-eyed administrators are seeing a suffering component.

That is how Dr. Michael Bennick, the medical director for patient experience at Yale-New Haven Hospital, solved a problem. He noticed a question on a Medicare survey asking, Is it quiet in your room at night?

Maybe, Dr. Bennick thought, what is really being asked is: Can you get a good night’s sleep without interruption? Is it really necessary to wake patients again and again to take blood pressure and pulse rates, to draw blood, to give medications?

He issued instructions for his unit. No more routinely awakening patients for vital signs. And plan the timing of medications; outside intensive care units, three-quarters of drugs can be given before patients go to sleep and again in the morning.

Then there were the blood tests. “Doctors love blood tests,” Dr. Bennick said, and want results first thing in the morning when they make rounds. That meant waking patients in the wee hours.

“I told the resident doctors in training: ‘If you are waking patients at 4 in the morning for a blood test, there obviously is a clinical need. So I want to be woken, too, so I can find out what it is.’ ” No one, he said, ever called him. Those middle-of-the-night blood draws vanished.

Without anything else being done about noise in the halls, the medical unit’s score on that question rose from the 16th percentile to the 47th nationally in the Medicare survey. Now the entire hospital follows that plan.

“And it did not cost a penny,” Dr. Bennick said. “The only cost was thinking not from our perspective but from a patient’s perspective.”

Dr. Lee says he joined Press Ganey — he had been network president for Partners HealthCare System, a Harvard-affiliated hospital system — because one of its goals was to reduce suffering. At first, he said, he was a bit uncomfortable with the concept.

“I wondered whether it was a tad sensational, a bit too emotional,” he wrote in The New England Journal of Medicine. Then he realized reducing suffering was one of the most important challenges in health care.

Press Ganey administers detailed surveys to discharged patients, asking things like how well the medical staff responded to them and their emotional needs, and how well the doctors and nurses informed and educated them. The company also encourages hospitals to let doctors know the results.
Surveys can be misleading, though, cautions Dr. Scott Ramsey, a health care economist and cancer researcher at the Fred Hutchinson Cancer Research Center in Seattle. Patients, worried about saying something bad about a hospital they depend on, may not reveal what they really experienced. Or they may look back and, not wanting to live a life of regrets, excuse a doctor who seemed not to listen.

On the other hand, Dr. Ramsey said, the suffering issues are real, and if survey answers can get doctors and hospitals to change their ways, “that is great.”

Although half the nation’s hospitals use Press Ganey surveys, it is not clear what many do with the data. But at some places, like the University of Utah, the survey and other efforts prompted significant change. One Utah doctor said he was stunned when his patients rated him in the first percentile nationally, about as low as a score can go. “I was thinking: That’s just crazy. Something wasn’t entered right,” said the doctor, James Ashworth. Then he decided to take the criticisms to heart.

The next quarter, he was rated in the upper 90s. The big difference was slowing down and listening to patients, answering their questions.

Utah began its program a few years ago by showing its 1,200 doctors, nurses and other workers their scores. Next, said Dr. Vivian S. Lee, the hospital system’s chief executive, they showed them how colleagues did. Then they posted individuals’ scores and patient comments online.

There was an immediate and noticeable change. When the university began, it was in about the 30th percentile nationally on the Press Ganey survey. Now, half its providers are in the 90th percentile and 26 percent are in the 99th percentile.

“It’s unbelievable,” Dr. Lee, the chief executive, said. “We were not like that before, I can tell you.”

“People wanted to improve,” she added.

The comments, she said, are more revealing than the scores. Not all are complimentary. “There are still cases where people say: ‘I loved Dr. So-and-so. Too bad I had to wait so long to see him,’ ” she said.

At Stanford Health Care, said Amir Rubin, the president and chief executive, “we are reducing suffering.” To do it, the medical system changed its focus.

“We train each and every staff member,” Mr. Rubin said. “We talk to staff, we talk to patients, we hear from patients directly.”

Supervisors coach doctors and nurses, giving feedback every month.

The initiative changed hiring, he said. Administrators tell job candidates: “These
are our care standards. Do you think you can always do it for every person every
time?” They carefully observe new hires to see if they can provide care that
minimizes suffering.

“Every patient visit is a high-stakes interaction,” Dr. Thomas Lee says he has
learned. “It is a big deal for the patient and it is a big deal for you.”

“And all you have to do is be the kind of physician your patient is hoping you
will be.”

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