

LEAVING EMPLOYMENT

Burned Out as an Employed Physician? Your Actual Options, Ranked

Burned-out employed physicians have five real options: renegotiate, switch employers, cut hours, go non-clinical, or go independent. Ranked with tradeoffs.



SCAN TO BOOK A CALL

openwellhealth.com/book-a-call

Updated June 2026 · ~8 min read

A burned-out employed physician has five realistic options: (1) renegotiate your current role, (2) switch employers or settings, (3) cut clinical volume — part-time, locums, telehealth, (4) move to non-clinical work, or (5) go independent and run your own practice. **The right option depends on the root cause: if your burnout is about hours, options 1–3 can work; if it's about control, only independence fixes the cause — but it costs the most to execute.** Rank them against your actual problem, not against what worked for someone else.

First, the necessary caveat that isn't a formality: burnout can carry real mental-health weight. If what you're feeling goes beyond work frustration — if it's depression, hopelessness, or worse — please talk to a professional or a trusted colleague before making any career decision. The rest of this article is about the structural problem; it is not a substitute for taking care of yourself.

Why "what's the root cause?" comes before "what should I do?"

Physician burnout usually isn't about working hard — physicians have always worked hard. The literature consistently points to **loss of autonomy** as a primary driver: someone else sets your schedule, your panel size, your visit length, your documentation burden, and your pace. That distinction matters because the five options fix different things.

Run the same diagnostic from [Should I Leave My Hospital Job to Start My Own Practice?](#): would your top three frustrations exist at the employer across town? If no — your problem is this job, and the cheap options below will work. If yes — your problem is the employment model itself, and the cheap options will buy relief, not repair.

The supporting data is hard to ignore. According to the AAFP, 49% of physicians in direct primary care report *no* burnout, versus 14% of non-DPC physicians — and 94% of DPC physicians report satisfaction with their practice versus 57% of non-DPC peers. Self-selection inflates those numbers somewhat, but the size of the gap tells you something true: the physicians who got the control levers back report dramatically different working lives.

Should I quit medicine entirely if I'm burned out?

FROM THE BRIEF

The five options, ranked from least to most disruptive

This ranking is by disruption and cost to execute — not by effectiveness. Effectiveness depends on your root cause, which is the whole point.

Option 1: Renegotiate where you are

Ask for the specific fix: panel cap, protected admin time, schedule change, call reduction, scribe support. Lowest effort, fully reversible, keeps your income and benefits intact.

Works when: the problem is one or two specific, nameable conditions of your current role, and your employer values retaining you. **Fails when:** the problem is the model — no negotiation restores autonomy over how medicine gets practiced in a system built on throughput. Also fails when the employer agrees in words and the dashboard quietly wins anyway.

Option 2: Switch employers or settings

A different group, a smaller practice, outpatient instead of inpatient, a different system's culture. Moderate disruption: a job search, possibly a move, and — check this first — your non-compete may constrain where you can go. [Physician Non-Compete Clauses, Explained](#)

Works when: your diagnosis really did come back "employer-specific." Some shops really are better run. **Fails when:** the frustration is structural. You're still inside someone else's system, and the same incentives follow you. Physicians who serially switch employers chasing relief are usually treating a structural problem with an employer-specific remedy — this is the single most common mismatch (more below).

Option 3: Cut or redirect clinical volume — part-time, locums, telehealth shifts

Reduce the dose. Part-time at your current employer, locums on your own calendar, or telehealth shifts with defined hours. Moderate disruption, with a real income cut, possible benefits changes, and — for locums — variable stability.

Works when: burnout is acute and volume-driven, or when you need breathing room to think clearly about the bigger move. Locums also delivers a partial autonomy fix: you control when you work, if not how. **Fails when:** the problem is meaning and control rather than dose. Many physicians find part-time trades income for relief without restoring the reason they liked medicine — you do less of a job that still isn't yours.

Option 4: Leave clinical practice — non-clinical roles

Utilization review, pharma and industry, informatics, education, administration. High disruption to identity and trajectory; often comparable or better hours, variable compensation.

Works when: you're done with clinical care and want out, not relief. For that physician, it's the honest answer, and it beats white-knuckling a clinical career. **Fails when:** you still love the medicine and hate the system around it. Then non-clinical work removes the system *and* the medicine — many physicians in this position report trading burnout for emptiness. Be very sure which part you're trying to escape.

Option 5: Go independent — your own practice

Run your own cash-pay or direct-care practice. Highest disruption and cost to execute: you become a small-business owner, income ramps over months (plan 6–12 months of personal runway and a 6–18 month panel build), and the launch itself is an operational project — entity, licensing, EHR, compliance, branding.

Works when: the root cause is control. This is the only option on the list that returns every lever — schedule, panel size, visit length, documentation style, who you answer to. It's the option the burnout data points at: the AAFP satisfaction and burnout gaps above come overwhelmingly from physicians who made exactly this move. **Fails when:** you don't want to own a business, your market won't support cash-pay care, or you leap without runway or a plan for the operational load. Independence fixes autonomy; it does not fix everything, and it adds ownership stress that options 1–4 don't carry.

Critically, option 5 is no longer all-or-nothing: the foundation can be built — and demand tested with a small side panel — while you're still employed and salaried, which converts the riskiest option on this list into a staged, reversible one. [How to Test Your Own Practice Without Quitting Your Job](#)

The options side by side

EXHIBIT					
OPTION	FIXES	DOESN'T FIX	REVERSIBILITY	INCOME IMPACT	TIME TO RELIEF
1. Renegotiate	Specific role conditions	The employment model	Full	None	Weeks
2. Switch employers	A bad shop, bad manager	Structural autonomy loss	High	Neutral	2–6 months
3. Part-time / locums	Volume, acute exhaustion	Control and meaning	High	Cut proportional to hours	1–3 months
4. Non-clinical	The clinical system entirely	Missing the medicine	Partial (clinical re-entry gets harder)	Varies	3–12 months
5. Independence	Autonomy — the root cause	Ownership stress, ramp risk	High if staged on the side; low if you leap	Dips during 6–18 month panel ramp, then competitive	Months, staged

What people get wrong: solving a control problem with a volume solution

The most common failure pattern in physician burnout isn't choosing a bad option — it's choosing a mismatched one. The physician whose real problem is autonomy goes part-time, feels better for six months, and then notices the same dread in fewer hours. Or switches employers, enjoys the honeymoon, and watches the same dashboard pressures reassemble within a year. Each mismatched fix costs a year and a little more hope, which is precisely how people end up cynical about every option.

The second mistake is sequencing: making any major move before reading your contract. Your non-compete, moonlighting clause, tail-coverage obligation, and clawbacks determine which options you can actually execute and what each costs. A physician with employer-paid tail, a narrow non-compete,

and a permissive moonlighting clause has all five options open. A physician with self-paid tail, a metro-wide non-compete, and a long clawback has maybe two — and should know that before deciding anything. [How to Know If Your Physician Employment Contract Is Fair](#)

Reality check

- **Independence is one option, not the answer.** It carries the highest execution cost on this list, and it's wrong for physicians who don't want ownership, lack runway, or practice in a market that won't support cash-pay care. The data favors it *for the autonomy-driven* — that's a conditional, not a universal.
- **Every option has a real cost.** Renegotiation can stall your standing; switching costs momentum; part-time costs income; non-clinical can cost clinical identity and re-entry; independence costs ramp months and ownership stress. There is no free option — only the one whose cost buys the fix you actually need.
- **Relief and repair are different purchases.** Options 1–3 mostly buy relief; option 5 buys repair (for control-driven burnout) at a higher price; option 4 buys an exit. Confusing the three is how physicians spend years cycling.
- **Don't decide at your lowest point.** Acute burnout distorts judgment in both directions — toward paralysis and toward dramatic exits. Use option 3 to buy thinking room if you need it; make the structural decision from stable ground.

Frequently asked

Should I quit medicine entirely if I'm burned out?

Only if it's the medicine you want to escape, not the system around it. Per the AAFP, 94% of DPC physicians report satisfaction versus 57% of non-DPC peers — strong evidence that for many burned-out physicians, the problem is the practice model, not the profession.

Does going part-time fix physician burnout?

It reliably helps volume-driven, acute burnout, and it's a good way to create thinking room. It tends not to fix autonomy-driven burnout — you do fewer hours inside the same loss of control.

Is locums a good option for a burned-out physician?

It's one of the better intermediate moves: you control your calendar, escape your current shop, and keep earning while you decide. It doesn't give you your own panel or practice style, so for control-driven burnout it's a bridge, not a destination.

Can I start my own practice without quitting my hospital job first?

Often yes, depending on your contract's non-compete and moonlighting clauses. The foundation (entity, licensing, branding) generally isn't the practice of medicine, and a small cash-pay side panel where permitted lets you test demand while salaried. [How to Test Your Own Practice Without Quitting Your Job](#)

How do I know if my burnout is about hours or about control?

Ask whether a 20% reduction in volume at your current job would actually fix it. If yes, it's hours — negotiate or cut volume. If you'd still dread the structure of each visit, it's control — and structural options are the ones worth pricing.

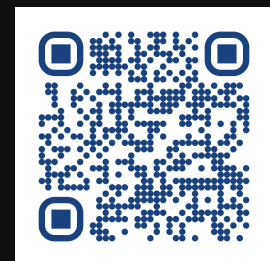
Which option is the safest?

Renegotiating costs nothing and is fully reversible, so start there even if you expect to be told no — the answer is itself diagnostic information. The safest version of the boldest option is the staged side-launch, because it keeps your salary while you test.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

If your honest answer keeps coming back to “control,” the cheapest next step is finding out whether your contract leaves room to test independence on the side. Openwell's free contract check answers that in about two minutes — and for physicians who go forward, we build and run the entire practice so the launch doesn't land on an already-burned-out plate.



SCAN TO BOOK

[Book a call → openwellhealth.com/book-a-call](https://openwellhealth.com/book-a-call)

RELATED OPENWELL BRIEFS

- [Should I Leave My Hospital Job to Start My Own Practice? An Honest Framework](#)
- [How to Know If Your Physician Employment Contract Is Fair](#)
- [Physician Non-Compete Clauses, Explained: What They Mean and Whether Yours Is Enforceable](#)
- [How to Test Your Own Practice Without Quitting Your Job](#)