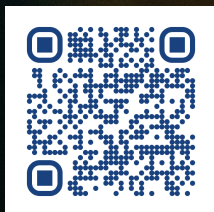


LEAVING EMPLOYMENT

Should I Leave My Hospital Job to Start My Own Practice? An Honest Framework

Leave when your dissatisfaction is structural, you have 6–12 months of runway, and a launch plan. An honest framework — including when staying is right.



SCAN TO BOOK A CALL

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Leaving employed medicine to start your own practice makes sense when three things are true: your dissatisfaction is structural rather than employer-specific, you have 6–12 months of personal runway, and you have a realistic plan for the operational work of launching. **If your frustration would follow you to the next employer — lost autonomy, compressed visits, documenting for billing — independence is the only option that fixes the cause.** If the problem is a fixable schedule or a bad manager, staying or switching is often the better move. And the decision is not binary: you can test independence before you resign.

BY THE NUMBERS

42%

of physicians remain in private practice
(AMA, 2024)

94% / 57%

DPC vs non-DPC report satisfaction
(AAFP)

~3,000

Direct Primary Care practices nationwide

Is your problem the employer, or the structure?

This is the diagnosis everything else depends on, and most physicians skip it. There are two distinct reasons doctors want out, and they have different correct answers.

Employer-specific problems — a bad manager, an unreasonable call schedule, a specific RVU target, a toxic group — can sometimes be fixed by renegotiating or by switching groups. If that's your situation, a job change is faster, cheaper, and less risky than a launch. [Burned Out as an Employed Physician? Your Actual Options, Ranked](#)

Structural problems travel with you. Loss of autonomy over your schedule and panel. The 12-minute visit. Documentation built for billing rather than for patients. Clinical decisions shaped by administrators who have never met your panel. If these are your complaints, another employer rarely

fixes them, because every employer runs the same model. Independence does fix them, because it returns the levers — schedule, panel size, visit length, who you answer to.

A practical test: write down your top three frustrations, then ask of each, "would this exist at the hospital across town?" If the answer is yes for all three, your problem is structural.

EXHIBIT

YOUR COMPLAINT	LIKELY CATEGORY	LIKELY FIX
My direct manager, my specific call schedule, this RVU target	Employer-specific	Renegotiate or switch employers
Visit length, panel size, documentation burden, who decides how I practice	Structural	Independence (or a structurally different model like DPC)
Total clinical hours, exhaustion regardless of setting	Volume	Part-time, locums, or reduced scope first

The satisfaction gap is the most striking number.

FROM THE BRIEF

The three-part readiness check

If the diagnosis comes back "structural," run these three checks before doing anything irreversible.

1. **Conviction.** Is the dissatisfaction durable or a bad quarter? Track it for 60–90 days. Keep notes. If the same frustrations show up week after week regardless of circumstances, it's structural and durable. If it spikes and fades with a rotation or a season, wait.
2. **Runway.** Plan for **6–12 months of personal expenses** in reserve. New cash-pay practices can reach a sustaining panel in months rather than years, but revenue ramps as the panel fills —

most physicians should model a 6–18 month build to a full panel. Independence is dramatically safer when it isn't desperate.

3. **Operational load.** This is where most physicians actually stall — not on desire, not on clinical ability, but on the hundred setup tasks: entity formation, EIN, NPI, malpractice, banking, HIPAA, licensing, DEA, branding, EHR. Individually each is trivial; collectively they're paralyzing, especially attempted at night around a full-time job. The honest question isn't "can I do this?" but "what's my plan for getting it done?" — yourself over 6–12 months, or delegated to a launch service in a compressed timeline. [Do You Need a Consultant to Start Your Practice? DIY vs. Consultant vs. Done-for-You](#)

If all three checks pass, you're a genuine candidate. If runway fails, fix that first — it's the most mechanical of the three. If operational load is the only blocker, note that it's the most solvable one in 2026.

What do the numbers actually say?

Some context for the decision, because the conventional wisdom ("everyone's employed now, independence is dead") is half right and importantly wrong.

The consolidation trend is real. Per the AMA's 2024 Physician Practice Benchmark Survey, fewer than half of U.S. physicians — roughly 42% — remain in private practice. In 2024, 34.5% of physicians worked in hospital-owned practices and 12.2% were directly employed by or contracted with hospitals, up from 23.4% and 5.6% in 2012. By broader definitions that include corporate entities, roughly 80% of physicians are employed by or affiliated with hospitals and corporate entities (Physicians Advocacy Institute/Avalere reporting). That's a historic inversion of how American medicine was organized.

The counter-trend is also real. Direct primary care has grown from a fringe idea to roughly 3,000 practices nationwide (the DPC Frontier mapper counts about 3,081 across all 50 states; the DPC Coalition cites 2,300+ practices serving 300,000+ patients). Per the AAFP, the share of surveyed family physicians operating a DPC practice rose to about 9% by 2023. Physician-sentiment surveys repeatedly find a substantial minority — by some measures roughly a third — actively considering leaving their current practice situation.

The satisfaction gap is the most striking number. According to the AAFP, 94% of DPC physicians report being satisfied with their practice, versus 57% of non-DPC physicians — and 49% of DPC physicians report no burnout, versus 14% of their non-DPC peers. Self-selection inflates this somewhat; physicians who choose independence wanted control. But even discounted, the gap is

large and consistent: for physicians whose dissatisfaction stems from loss of control, independence targets the actual cause.

When staying employed is the right answer

An honest framework has to include this, because sometimes the answer is no. Stay (or switch employers rather than launch) if any of these describe you:

- **You prefer zero administrative ownership.** Independence means being a small-business owner. You carry overhead, make operational decisions, and own outcomes. If a fixed salary with someone else handling the business is what you actually want, employment is a rational choice — and there's no shame in it.
- **Your income depends on high-volume, insurance-reimbursed procedures.** Cash-pay models fit longitudinal, relationship-based care best. If your economics require facility-based procedural volume, the independent cash-pay math is much harder.
- **You have no runway and can't build it soon.** Launching from financial desperation forces bad decisions — underpricing, premature scaling, panic during the ramp.
- **Your dissatisfaction is truly employer-specific.** Switching groups is a two-month fix, not a twelve-month project.
- **You haven't pressure-tested local demand.** The biggest unknown for any individual launch is whether enough patients in your area will pay cash for your care. If you can't tolerate that uncertainty, test it before you leap — or don't leap.

What people get wrong: treating this as a quit-or-stay decision

The framing of the question — "should I leave?" — contains the most common mistake. It assumes a binary leap. It isn't one.

The foundational steps of a practice — entity formation, licensing, branding, a basic patient-facing presence — generally aren't "the practice of medicine" and can usually be completed while you're still employed, subject to your contract. Where your contract permits, you can even see a small cash-pay panel on the side and validate demand before you give notice. Check your non-compete and moonlighting clauses first; they set the boundaries. [Physician Non-Compete Clauses, Explained How to Test Your Own Practice Without Quitting Your Job](#)

This reframing changes the risk math entirely. The question stops being "do I bet my livelihood on this?" and becomes "do I spend some evenings and a modest budget finding out, with my salary intact the whole time?" The physicians who regret leaving are usually the ones who leapt without modeling. The ones who regret staying are the ones who never let themselves run the numbers.

Timing also matters less than people think. A fully DIY launch commonly takes 6–12 months; a cash-pay launch with the operational work delegated can go live in roughly 4–6 weeks, largely because cash-pay models skip commercial payer credentialing, which alone runs 90–150 days. [How Long It Actually Takes to Open a Private Medical Practice](#)

Reality check

The honest downsides, so you can weigh them properly:

- **Income dips before it recovers.** Revenue ramps as the panel fills — plan on 6–18 months to a sustaining panel, and 6–12 months of personal runway. There is no version of this without a lean period unless you build the panel on the side first.
- **Demand is not guaranteed.** Cash-pay works in most markets but not all, and not at every price point. A practice with low local demand or fear-based underpricing can fail. This is the single assumption most worth testing before resigning.
- **You become an owner.** Even with everything delegated, you make business decisions: pricing, scope, growth, staffing. Some physicians find this energizing; some find it a second job. Know which you are.
- **Your contract can block you outright.** A broad, enforceable non-compete can keep you from practicing in your community for 1–2 years after you leave. This varies by state — a handful of states largely ban physician non-competes — but treat yours as binding until reviewed by a healthcare attorney licensed in your state. [How to Know If Your Physician Employment Contract Is Fair](#)
- **The most common failure mode isn't bankruptcy — it's stalling.** Most aborted launches die in the setup phase: the physician starts the paperwork, gets buried, and quietly gives up. If you go, go with a plan for the operational work, not just conviction.

Frequently asked

Is it worth leaving employed medicine to go independent in 2026?

For physicians who value autonomy and can tolerate ownership, the trade is more favorable than it has been in years: cash-pay models are mature (roughly 3,000 DPC practices nationwide), and the operational launch can now be delegated rather than done by hand. It's not worth it if you want zero business ownership or your income depends on insurance-reimbursed procedural volume.

How much money do I need before leaving my hospital job?

Plan 6–12 months of personal expenses as runway, because panel revenue ramps over months rather than arriving on day one. You need less if you build a side panel before resigning, which is the lower-risk sequence. [How Much It Costs to Start a Private Medical Practice \(Real Numbers\)](#)

Are independent physicians actually happier?

The data says yes, with a self-selection caveat: per the AAFP, 94% of DPC physicians report satisfaction versus 57% of non-DPC physicians, and 49% report no burnout versus 14%. The driver is control over schedule, panel, and visit length.

Can I start a practice without quitting first?

Usually yes, subject to your contract's non-compete and moonlighting clauses. The foundation — entity, licensing, branding — generally isn't the practice of medicine, and many physicians build it while employed, then see a small cash-pay panel where permitted. [How to Test Your Own Practice Without Quitting Your Job](#)

How long does it take to open a practice if I do leave?

DIY, commonly 6–12 months. A cash-pay practice with the setup delegated can go live in roughly 4–6 weeks, mostly because skipping insurance means skipping the 90–150 day commercial credentialing wait.

What if I run the numbers and they don't work?

Then you've spent a few evenings learning something important, and you still have your job. That's the point of modeling before deciding — a "no" from a spreadsheet is far cheaper than a "no" from a failed launch.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

If your answer is “maybe,” start with your contract and your numbers, not a resignation letter. Openwell’s free contract check shows in about two minutes whether your agreement leaves room to start on the side — and for physicians who go forward, we build and run the entire practice end to end: entity, licensing, EMR, compliance.



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