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If you spend much time on physician social media or in the medical trade press, you'll encounter a lot of grief about the corporate takeover of American medicine. You'll see physicians lamenting their lost autonomy. You'll read of administrators multiplying like untreated strep. You'll hear that the assembly line is replacing the exam room.

All of it is accurate, but none of it actually useful.

Here's what the coverage almost uniformly misses: the factory is creating the opening for you.

What the Rent Seekers Actually Are

The term "rent seeker" has a specific meaning in economics. A rent seeker extracts value from an existing resource or relationship rather than creating new value. The classic example is the toll collector: he adds nothing to the journey; he merely occupies the bridge and charges for passage.

Hospitals and corporate entities that employ physicians perform, in substantial part, exactly this function. They sit between the physician and the patient (and increasingly between the physician and every other relationship that defines a practice) and extract economic rent from those relationships.

The administrative infrastructure they construct, sold to physicians and even to the public as "support," is in reality the mechanism by which they harvest that rent. Every layer of policy, every mandatory EHR module, every VP of Physician Relations is, from a strict economic standpoint, a cost imposed on the physician's productive output that the physician does not control and does not benefit from.

Those numbers tell you how many physicians are inside the factory. But they don't tell you what the factory is producing.

What the Factory Produces

Every factory produces what factories are designed to produce: standardized output at maximum throughput. Protocol-driven care. Seven-minute appointments. Productivity dashboards. Physicians executing workflows they didn't design, subject to administrative decisions they didn't make, in service of financial objectives in which they don't share.

WittKieffer's 2026 State of Physician Leadership survey found that physician executives inside health systems spend an average of 22% of their time on administrative and operational duties that pull them away from actual leadership. And that's the physician executives, the ones nominally in charge. Ask a line physician how much of their day involves something other than caring for patients, and 22% will seem optimistic.

The factory also produces something its architects didn't intend: a growing, legible gap between what it delivers and what medicine actually is.

Patients feel this. Referring physicians feel this. Sophisticated payors are beginning to quantify it. The factory's output, what I call "meh" care as opposed to medical care, is not invisible. It's increasingly recognizable, precisely because it is so uniform. And when everyone can identify what the factory looks like, the alternative becomes visible too.

The Opportunity in the Gap

Here's the economic logic the grief-merchants on social media miss.

When 82% of physicians are inside the factory and the factory is optimized for throughput rather than for care or quality, two things become true simultaneously. First, the supply of genuinely differentiated physician-led care contracts sharply. Second, demand for that care, from patients who can choose, from referral sources who notice the difference, from facilities that want a partner rather than a vendor, does not contract at all.

Constrained supply. Sustained demand. The economics of that combination aren't complicated.

The physician-owned practice that competes on true clinical quality, on depth of relationship, on access, on accountability, is not swimming upstream. It's swimming in a different pool entirely, one the rent seekers cannot easily enter, because their entire model depends on scale, protocol, and administrative control. Those are precisely the tools that disqualify them from this competition.

What I have long called an Experience Monopoly™ — the creation of a practice experience that is, by design, unreplicable by competitors — is far easier to build when your competitors are a factory. The factory can copy your EHR system. It cannot copy your culture, your relationships, your availability, your clinical depth, or your willingness to solve a problem the factory's algorithms aren't designed to handle. The factory's economics, in fact, require it not to offer those things. That constraint is your competitive asset.

The Financial Case Is Stronger Than the Satisfaction Case

Physicians who argue for independence on quality and satisfaction grounds are right. But they sometimes undersell the financial argument, which is, if anything, more powerful.

The difference between what an employed physician produces and what that physician is paid to produce it is not a rounding error. Across most specialties, the economic surplus captured by the employing entity is substantial. It funds the hospital's administrative infrastructure, the corporate entity's investor returns, and every layer of the rent-seeking apparatus in between.

Physician owners capture that surplus. Physician employees fund it.

This is not a philosophical point. It is arithmetic.

Some Takeaways for You

1. **Stop treating the consolidation statistics as your problem.** The consolidation of the 82% is not a threat to the 18% who understand how to use the gap it creates. It is a competitive gift, provided you stop mourning it and start exploiting it.
2. **Physician-owned and physician-led is a marketable differentiator, not just a description.** Make it explicit. Make the case, to patients, to referring physicians, and even to facilities, for why it matters. The factory's market dominance has made this distinction meaningful in a way it wasn't twenty years ago.
3. **Think broadly about what physician ownership can encompass.** A lean, physician-led specialty practice is one answer. An integrated outpatient campus such as on including a surgery center, aftercare facility, medical office building, and imaging center, is another. The rent seekers control the hospital. They don't control the space adjacent to it, and the long-term shift toward outpatient care continues to expand that space.
4. **Quantify the economic case for ownership before you negotiate anything.** The difference between what you produce and what you're offered to produce it as an employee is a number. Know the number. It belongs in your strategy, not as an afterthought.
5. **Your recruiting pitch writes itself.** The factory has a retention problem because it cannot offer what you can: clinical autonomy, ownership economics, and a practice environment built for physicians rather than for administrators. When the workforce is tight, and it is, this is not a minor advantage.

The rent seekers are building a factory. Factories are excellent at producing commodity products at scale. You're actually free to choose whether to work in it or somewhere else.

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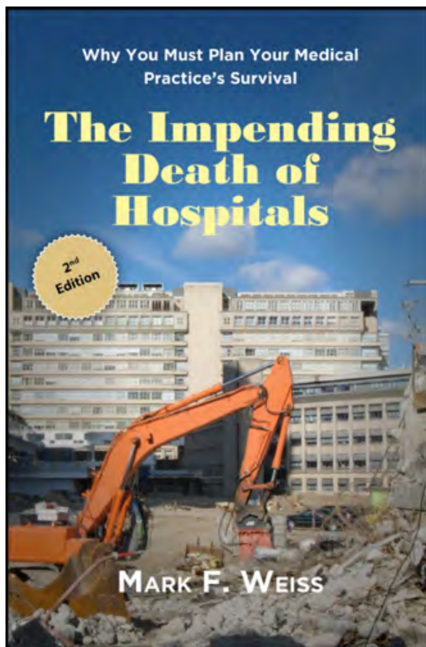

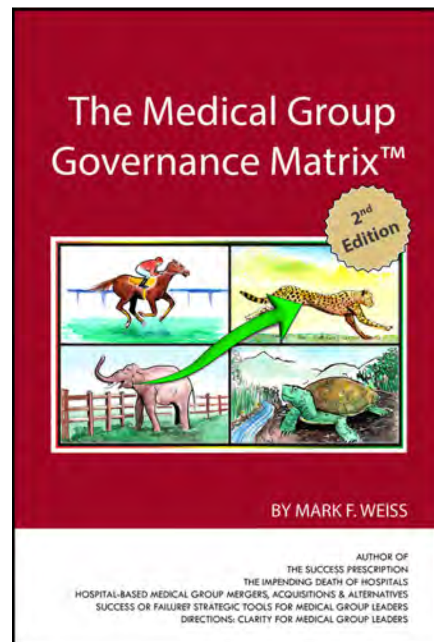

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