

Clinician, who are you?

Commentary

Dear colleagues, please allow us some time to discuss case management and diagnostic formulation peer-to-peer. It is becoming increasingly common and difficult to open EHR and look at the diagnosis list that looks like “select all” was clicked. While clinician training and supervision are an important component of this conversation, it does not seem limited to experience level, discipline, region, or network, but instead seems to be a part of the clinical culture at this historical period. On a very appreciable scale, the clinicians seem to have stopped considering that somnolence, low energy/fatigue, and reduced ability to concentrate on a task are already described by a major depressive disorder diagnosis (*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013);¹ depressed and anxious moods are routinely seen in stress-trauma related,² neurodevelopmental,^{3,4} and personality disorder diagnoses.⁵ Prevalence of a mood disorder co-diagnosis in an endocrine diagnosis with symptomatic overlap is reported to range between 1.8 and 88%.⁶

These do not have to be a multiple-diagnosis referral to a specialist that may not exist. The previous generations carried diagnostic formulation with reverence: a diagnosis can increase awareness, connection to resources, and provide normalization; and it can, simultaneously, increase stigma, costs, and burdens to the patient. To be fair, the diagnostic system, rightfully, has flexibility and symptomatic overlap can be seen in many diagnoses – reasonable minds can often disagree. The responsibility on the clinician is to review the record for what was previously done, perform an evaluation, and devise the most concise diagnosis, or co-occurring diagnoses, that fully describe the struggles of the patient with minimal possible negative impact on the patient. It would be very easy to assign Not Otherwise Specified diagnosis to nearly everyone; that is not what we spent years in school, and in practice, to learn and refine. There are, certainly, cases/times when important diagnostic information is missing: the labs may be pending, the family may still be on the way but has not yet provided history, etc., and the diagnostic system is prepared for this – a provisional diagnosis carries a very different connotation vs. a differential diagnosis. Ultimately, there is a human being in front of a clinician who is struggling: they may not be the best of historians, they may be over- or under-expressing symptomology for a multitude of reasons, they may be following the advice of Dr. Google. Our care can make that individual better or worse and with that comes the responsibility to do everything possible to not only avoid harm, but also to be purposeful, intentional, and conscientious with the care provided.

Colloquially speaking, an administrative diagnosis can serve an important purpose. A large number of agencies/organizations have target populations. A diagnosis of ADHD may not connect an individual to much-needed services if the available provider organization is focused on/dedicated to serving a PTSD population, for example. The overlap of symptoms is broad,⁷ there is no radiology or a blood test to objectively identify one vs. the other; the history provided may be incomplete or biased, while psychological testing/assessment requires both time and resources. An argument can be successfully made that a less ‘perfect’ diagnosis serves the needs of

Volume 10 Issue 4 - 2026

Michael Ginzburg

PsyD, LMFT; Kristina Netherton LMFT, USA

Correspondence: Michael Ginzburg, PsyD, LMFT; Kristina Netherton LMFT, USA**Received:** September 02, 2026 | **Published:** September 16, 2026

this hypothetical patient. In the context of culture, stigma, insurance rates, treatment adherence/success... this does not seem assured and the potential for harm can't be ignored. The progress note is a legal document protected by legal, ethical, and clinical guardrails. It needs to be respected as such.

‘Professional tunnel vision’ can be a great source of distress to both patients and team members. Imagine a case of an individual endorsing knee pain. The etiology could involve the knee itself, proximal stability of the hip joint, or distal alignment of the foot/ankle. Ignoring posture or footwear complicates the conversation between the patient and the clinician referred to in an effort to address the challenge. “This is the first time I’ve ever heard this, my doctor didn’t have any issues with my shoes and I wore them to that appointment,” and the conversation with the referred-to specialist grinds to a standstill. The time between the primary care and the specialist visit is spent in pain, even if the specialist can overcome the hurdle. That individual has less motivation to trust both the primary care and the specialist and the dysfunction is further reinforced.

The clinician is the recognized holder of authority. In the US, it is the responsibility of the physician to demonstrate medical necessity to an insurer. “Per patient request” does not even suggest that the intervention is medically necessary and the insurer is free to deny that claim. In a clinical practice, there are times to accommodate, and there are times to challenge – that patient is coming to the provider for the provider’s expertise. The prescription of antibiotics for viral illnesses has led to the spread of formerly hospital-borne infections into the community and the rise of the so-called “superbugs”.⁸ It can absolutely be emotional, clinical, and time-management challenges to hold a clinical boundary. That boundary still matters.

Closed kinetic chain is a real biomechanical consideration.⁹ As students, we are taught to differentiate between a mood state and a mood disorder, and as soon as we don’t have to present a case to a preceptor, those skills can start to atrophy. We can do better, and real people’s lives are dependent on it. Dear colleagues: with great power, comes great responsibility.

Acknowledgements

None.

Conflicts of interest

The author declares there is no conflict of interest.

References

1. *Diagnostic and statistical manual of mental disorders: DSM-5*. 5th edn. 2013.
2. Barbano AC, Der Mei WF, DeRoos-Cassini TA, et al. Differentiating PTSD from anxiety and depression: Lessons from the ICD-11 PTSD diagnostic criteria. *Depression and Anxiety*. 2019;36(6):490–498.
3. Hollocks MJ, Lerh JW, Magiati I, et al. Anxiety and depression in adults with autism spectrum disorder: A systematic review and meta-analysis. *Psychol Med*. 2028;49(4):559–572.
4. Civan HY, Berkol TD. *Attention deficit hyperactivity disorder (Adhd) comorbidity in women with depression and anxiety: Prevalence, clinical features, and hyperfocus dynamics*. 2024.
5. Mesbah R, Bles N, Rius-Ottenheim N, et al. Anger and cluster B personality traits and the conversion from unipolar depression to bipolar disorder. *Depression and Anxiety*, 2021;38(6):671–681.
6. Harding KA, Pushpanathan ME, Whitworth SR, et al. Depression prevalence in type 2 diabetes is not related to diabetes–depression symptom overlap but is related to symptom dimensions within patient self-report measures: A meta-analysis. *Diabetic Medicine*. 2029;36(12):1600–1611.
7. Mariager T, Speyer H, Ponsaing L. Overlap between PTSD, ADHD, and narcolepsy. *Ugeskrift for Læger*. 2025;1–4.
8. Konde S, Jairam L, Peethambar P, et al. Antibiotic overusage and resistance: A cross-sectional survey among pediatric dentists. *Journal of Indian Society of Pedodontics and Preventive Dentistry*. 2026;34(2):145.
9. Pamboris GM, Pavlou K, Paraskevopoulos E, et al. Effect of open vs. closed kinetic chain exercises in ACL rehabilitation on knee joint pain, laxity, extensor muscles strength, and function: A systematic review with meta-analysis. *Frontiers in Sports and Active Living*. 2024;6.