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The Mystery of Long COVID Is Just the Beginning At Yale's clinic, medical sleuth Lisa Sanders is trying almost everything.

By Lisa Miller, who has been a writer on staff at New York since 2011

Photo: Sara Messinger

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Lisa Sanders was at a large birthday party in New Haven in June 2022. It was an evening in late spring, lovely enough for the party to spill out onto the lawn. Sanders, an internal-medicine doctor at Yale, was leaning against a doorway drinking a glass of wine and catching up with her friend Erica Spatz, a cardiologist, when Spatz mentioned that she and a few other doctors had the idea of starting a new long-COVID clinic at Yale. They were looking for an internist to run it.

The problem was one of volume, Spatz explained. Since the beginning of the pandemic, she — together with colleagues in the pulmonary and neurology departments — had been seeing long-COVID patients at Yale but often in an ad hoc way. Some of the doctors had become so flooded with people seeking help that they were having difficulty scheduling and treating their regular patients who came to them for everything else: lung cancer, asthma, heart disease, dementia. “My practice is so overwhelmed,” Spatz told Sanders.

Long-COVID patients, generally speaking, have been very miserable for a very long time, and because the illness attacks their brains, their hearts, their lungs, their guts, their joints — sometimes simultaneously, sometimes intermittently, and sometimes in a chain reaction — they bounce from specialist to specialist, none of whom has the bandwidth to hear their whole frustrating ordeal together with the expertise to address all of their complaints: the nonspecific pain, the perpetual exhaustion, the bewildering test results, the one-off treatments. “These are people who have not been able to tell their story to anybody but their spouse and their mom — for years sometimes,” Sanders tells me. “And they are, in some ways, every doctor’s worst nightmare.” From the perspective of a time-pressed physician under ever-more-stringent productivity expectations, who has at most 30 minutes to do a new-patient intake and 15 for a follow-up, “someone who comes in with a very long story — it just sinks your day,” Sanders says.

Long COVID has been pushing the limits of hospital systems everywhere, not just at Yale. As Americans emerged from the most acute phase of the pandemic, as mask and vaccine mandates lifted and life returned to a semblance of normal for the people who had contracted COVID and recovered, primary-care physicians started to say, “I’m not interested in long COVID,” or “I don’t treat long COVID. Let me refer you to a specialist,” said David Putrino, who runs the new chronic-illness recovery clinic at Mount Sinai. For their part, Putrino added, the specialists were saying, “This is not what my practice is. This is not an emergency anymore.” Patients all over the country reported monthslong waiting times for appointments at long-COVID clinics. All the while, scientists and pundits heaped skepticism on the very notion of long COVID, arguing that infection made people stronger, that new variants posed no threats, that the danger of long COVID was overblown — implying that what patients were suffering from was all in their heads.

Forgotten in this debate are the 65 million people worldwide for whom the pandemic remains a torturous everyday reality. Absent the kind of long-term studies that can provide more definitive answers on what long COVID is and how it can be treated, these people are in desperate need of clarity from someone devoted to their care. Spatz and her colleagues were proposing an alternative model: a clinic led by an internal-medicine doctor with a full hour to listen to each patient. This physician would create a treatment plan, communicate extensively with the patient’s primary-care team, and refer out to subspecialists when necessary. It wasn’t glamorous. It might never produce patents or profits or win prizes.

As Sanders listened to her friend unspool this idea, her excitement mounted. Hearing patients’ complicated problems and solving them was her sweet spot, the talent and interest upon which she had built a storied career. Now 67, she has long been known as the Arthur Conan Doyle of medical diagnosis, “a paragon of the modern medical-detective storyteller,” as the celebrated surgeon Atul Gawande once described her. In addition to

teaching internal medicine at Yale, she writes “Diagnosis,” a monthly medical-mysteries column for *The New York Times Magazine*, which was the inspiration for the long-running television series *House*. She has written two books on diagnosis and in 2019 was featured on a Netflix docuseries also called *Diagnosis*.

Sanders, energetic and brusque, had been casting about for her next challenge. And here, unexpectedly, it was. “I was like, *Yes! This is what I've been looking for,*” she tells me. The Monday after the party, Sanders sent an email inquiring about the position. “I was really the only qualified person who applied for the job,” she says. Among the ambitious academics at Yale, evaluating frustrated patients for long COVID — and then treating their ever-changing and unremitting symptoms — was not seen as an auspicious professional trajectory. But in their lack of interest, Sanders saw a path forward beyond diagnosis: As an internal-medicine doctor, she was already an expert at managing chronic disease. “There are no antibiotics for diabetes. There’s no magic pill for hypertension,” she says. She has spent more than two decades not offering cures but helping people improve their imperfect health. She could aim these skills at a new subset of patients suffering from this novel disease.

Before she was a doctor, Sanders was a journalist — a storyteller in a different sphere. She worked at CBS, producing news segments on science and medicine and collaborating with the network’s then–medical correspondent, Dr. Bob Arnot. The way she tells it in her 2009 book *Every Patient Tells a Story*, she decided to become a doctor after she watched Arnot rescue a drowning woman from a river and apply basic CPR. “Television reaches millions but touches few,” Sanders wrote. “Medicine reaches fewer but has the potential to transform the lives of those it touches.” She was in her early 30s when she went back to university to take the prerequisites for medical school and 36 when she was accepted at Yale.

At the time, she lived in New York. Her husband, Jack Hitt, is a journalist, and their friends were journalists and writers, people who tell stories for a living and for whom “a good story” is a kind of social currency. Upon starting her medical training, Sanders imagined that her best dinner-party anecdotes would be like the Arnot tale, stories of dramatic medical interventions and heroic derring-do. Instead, she found herself — and her dinner companions — far more captivated by the stories of diagnosis: “mysterious symptoms that were puzzled out and solved,” she wrote. As a student and a resident, she loved wending her way through a complex diagnostic profile and learning about a patient who didn’t fit the pattern, someone with inconclusive or contradictory test results and unusual or unexpected symptoms: “a wonderful piece of detective work — complicated yet satisfying.” Sanders had been an English major in college and found that medical diagnosis scratched the same itch

that reading a poem or reporting a story did. And yet she found that, in medicine, the aha moment at the end — the reveal — was so much more consequential because the answer could be lifesaving. Once a patient had a diagnosis, a doctor knew what to do.

Sanders had a friend who was an editor at *The New York Times Magazine*. “What can doctors write?” the friend asked her. A year later, the “Diagnosis” column was born.

The columns, and the subsequent episodes of *House*, followed a formula. A patient shows up at the hospital with dire unexplained symptoms. A young woman on the brink of death has a “highlighter yellow” complexion, a child with cancer has hallucinations, a perfectly healthy teacher collapses with seizures. The tests for the usual disease culprits come up negative. Doctor after doctor proposes hypotheses and orders more tests to no avail. And then one wise physician — sometimes in the columns it’s Sanders but more often not — reads all the available information from another angle and by turning the kaleidoscope just so, has the insight that leads to the diagnosis. It’s a rare genetic disease, a blood clot in the brain, a tapeworm.

Back then, Sanders perpetuated a rather romantic, old-fashioned view of medicine, in which great doctors are portrayed as maverick philosophers seeking deeper truths amid tryhards and technocrats. (Dr. House, the character played by Hugh Laurie, was the epitome of this: a misanthropic drug addict who was necessary to the hospital because of his diagnostic brilliance.) Sanders’s role, as she saw it, was to share with her students and the wider world her belief in the art of diagnosis as central to healing. A tenet of her value system even then was that doctors should become more comfortable with uncertainty and more willing to cop to what they do not know. “The fact is that, more often than doctors would like to admit, they cannot find a cause for a patient’s symptoms,” she wrote. Unknowing is the first step to solving the puzzle, she believed.

But even Sanders has sometimes succumbed to the most common of doctor diseases: groupthink and hubris. In the late 1990s, patients with a galaxy of unexplained chronic symptoms — including fatigue, sore throat, joint pain, insomnia, dizziness, brain fog, and depression — began to gather into activist and identity groups, calling themselves sufferers of “chronic Lyme.” They had something, they argued, related to a previous infection from the bite of a deer tick, but their doctors were dismissing them as whiners and neurotics. This was in an era when the medical Establishment was rolling its collective eyes at patients who were querying whether diagnoses of “chronic fatigue syndrome” or “fibromyalgia” might fit their symptoms — ones that looked very much like those linked to chronic Lyme. In the pilot episode of *House*, a zhlubby patient asks the doctor if he can be treated for chronic fatigue syndrome. When House raises his eyebrow, the patient suggests fibromyalgia. House gives him a vial filled with candy from the vending machine.

Sanders joined the chorus of debunkers. These patients had real symptoms and real ailments, she asserted in *Every Patient Tells a Story*. But the collection of symptoms was “hopelessly broad and overinclusive,” she wrote. “These are some of the most common symptoms of patients presenting to a primary care office.” She concluded that chronic Lyme was a “phantom diagnosis.”

“I completely regret that chapter,” she says now. “I would like to rewrite it.” Sanders explains that she was reacting to the doctors who were preying on suffering people by prescribing interminable courses of antibiotics that were not helping them: “But I completely misunderstood it. The patients were making the connection between their symptoms and Lyme disease.”

The path from dismissing chronic Lyme — now known as post-treatment Lyme disease syndrome — to embracing long COVID was one of professional maturing, from regarding uncertainty as a prerequisite to getting the right answer to understanding it as a fact of life. Young doctors, having spent the past three or four years with their heads in their books, can be “ready to feel absolutely certain that they know what to do,” Sanders tells me. But as she grows older, “I’m more interested in areas that are less clear. In helping people manage what’s going on. In continuously having to educate myself.”

Her job at the long-COVID clinic has plunged Sanders into the deep end of not knowing, just as research scientists are beginning to make some important discoveries. In May 2022, around the time of the birthday party in New Haven, an immunologist named Akiko Iwasaki, also at Yale, published with colleagues a review in *Nature Medicine* that placed long COVID within a family of post-acute-infection syndromes — including Lyme — that she believes are related. Among people who survive many common viral infections (Ebola, dengue, polio, influenza, and Epstein-Barr, for instance), a small percentage suffer for years with symptoms that are very similar to those of long COVID: extreme fatigue, brain fog, joint pain, inflammation, dizziness, sleep disruption, mood disorders. The same goes for people who get giardia, a parasite.

Iwasaki made the case not just that these syndromes were, obviously, real but that their pathogeneses — the way they get activated in the body and why, the exact cellular-level mechanisms — were somehow similar. If scientists could learn how common infections become chronic illnesses in some people but not in others (and what Lyme, a bacterial infection, has in common with mono, a viral one), researchers might develop treatments to attack root causes rather than symptoms. Long COVID provides science with an opportunity to learn how post-infection chronic disease originates and thereby to help hundreds of millions of people, Iwasaki told me. “We’re not paying enough attention,” she said. “We’re not. Doctors are still dismissing this disease as something that’s in your head. I

have seen the exchanges on Twitter: ‘Long COVID is exaggerated, not real.’” Women are diagnosed with long COVID at roughly twice the rate of men, Iwasaki pointed out: “I think if the situation was reversed, we’d pay even more attention to this disease.”

The *Nature Medicine* paper dovetailed with Sanders’s preexisting interest in unidentified conditions. “There are a lot of people who have diseases that we don’t have names for and certainly we don’t have tests for,” she says. She has come to believe that many of the run-of-the-mill complaints general practitioners see in their day-to-day, which they may be tempted to discount as psychosomatic or “sensitive” or hypochondriacal, do have a biological basis — probably far more than anyone knows or thinks. She then put forth what she calls her “crank theory” about the anxiety epidemic in Gen Z. “I wonder if they’re anxious not because the end of the world is coming,” she says, her tone both joking and not joking. “Maybe they’re anxious from something we’ve done to this planet, so they’re being exposed to something that’s making them feel this way. I just think that when everybody has something, it’s not psychology; it’s biology. But I’m not a researcher, so I don’t know.”

In medical schools, there’s a saying: When you hear hooves, think horses, not zebras. This means that when a patient presents with a cluster of symptoms, the cause is likely to be the likeliest one, not something exotic or rare. But even within the realm of the most common diseases, a range of diagnostic possibilities exists. A patient presenting with a fever and a rash could have “shingles, measles, scarlet fever, or Lyme disease,” Sanders tells me. “There are so many things it could be. It’s so broad you have to think it through — and that, to me, is extremely exciting.”

But even Sanders was not prepared for how little doctors and scientists know about long COVID. There is no blood test. Health officials can’t even agree on how to define it. The CDC describes long COVID as “signs, symptoms, and conditions that continue or develop after acute COVID-19 infection” — or, in Sanders’s paraphrase, “You got COVID and then something bad happened.” Under the CDC definition, patients have long COVID if they are symptomatic at least four weeks after initial infection. The WHO defines it similarly but with a different time frame: occurring or lasting at least three months after initial infection. This discrepancy matters to Sanders because, as much as possible, she wants to identify patients who have long COVID and not those who may take a little longer to recover from their original illness. In her clinic, she uses the WHO definition.

The symptoms of long COVID are like an encyclopedia of suffering; one paper in *eClinicalMedicine* describes more than 200 distinct symptoms of the disease. When patients talk about how they’ve been feeling lately, they can sound as if they’re possessed by demons. Sanders has one patient who on some days can walk from her car to the front door

of her office — 700 steps — and some days cannot, and she has encountered one man whose once merely irritating tinnitus has become deafening. “People come in with strange symptoms, like an internal tremor,” she says. “They’ll say, ‘It feels like my insides are trembling.’ This is not one person. This is lots of people.”

The most common symptoms of long COVID can have many causes. Brain fog, for example, is a medical catchall that means failures of memory and cognition and inability to concentrate. It can be part of ME/CFS, also known as myalgic encephalomyelitis or chronic fatigue syndrome, which shares many symptoms with longtail syndromes like long COVID. Or it can be a symptom of another disease: anemia, diabetes, Alzheimer’s. It can be a side effect of medication. Aging, menopause, stress, lack of sleep — all these can cause brain fog. In addition, “brain fog” has entered the vernacular in a casual way to describe office fatigue, pandemic fatigue, boredom, dissatisfaction, or the aftereffects of a long night out at the bar.

Sanders, more than ever before, is dependent on the patient’s account — on detailed specifics — to establish her diagnosis. It’s a process of elimination and deduction. So she has “learned just to shut the fuck up and listen.”

I visited Sanders’s office on a rainy day in August when she was meeting new patients. Jennifer is 61. She had always considered herself competent, energetic, active, organized. Methodical. But over the past three months, she started to become forgetful, so much so that her husband was making comments about it.

Jennifer first noticed her brain fog early one morning at her home office in East Haven when she found she couldn’t remember her computer login, which she had typed literally thousands of times. Over the next couple of months, the fog settled in. The system she built to keep track of her social-work clients sometimes befuddled her. She would be in the middle of a routine chore and suddenly feel like an alien at her own job: “All of a sudden, I’d be like, *Oh my gosh, did I get a new client that I maybe forgot?*”

And then there was the terrible fatigue. She had struggled over the past year with a pinched nerve in her hip, but now going up and down the stairs in her home became so exhausting that she took to sleeping on the living-room recliner. She realized she was becoming depressed.

Jennifer had gotten COVID once, as far as she knew, during the massive Omicron wave of 2021. It had been a mild case: a couple days of fever, a week of sluggishness, but with no aftereffects more severe than the ruination of Christmas. But now, she wondered. Could this state she was in — weak, depleted, vague, unfamiliar to herself — be somehow related to the virus?

Sanders aimed first at clinical dementia.

“Have you ever not recognized a person you know?” Sanders asked.

“No,” Jennifer replied.

“Have you ever gotten lost when you’re driving home?”

“No,” Jennifer said.

Having ruled out dementia, Sanders inquired about the timing and course of Jennifer’s COVID, the medications she takes for her diabetes, the pain in her hip. Then the doctor ran through an inventory of post-COVID symptoms. Does she get short of breath? No. Fatigue? Yes. Cough, chest pain, palpitations, headaches? Abdominal pain, diarrhea, unexplained fevers, lightheadedness, skin discoloration, rashes, or itching? “No,” Jennifer said. No, no, no, no. She said she does sometimes have a racing heart, joint pain, and numbness or tingling in her hands and feet.

Then Sanders interrogated Jennifer about her fatigue: After she exerted herself, did she feel tired? Or not until the next day or several days after? Here, she was looking for signs of post-exertional malaise, a feature of long COVID in which patients do not recover after resting but run out of gas. When Sanders inquired about her quality of sleep, Jennifer described the living-room recliner.

Sanders puts most of her patients, including Jennifer, through the most basic of physical tests. To measure their endurance, she asks all of them to walk as quickly as they can around the halls of the hospital for six minutes. She asks them to go from sitting to standing as many times as they can in one minute. Many patients say they feel better lying down than standing up; these she tests for POTS, or postural orthostatic tachycardia syndrome, which has frequently been documented in long-COVID cases.

A physical therapist and a nurse ran Jennifer through these tests and then Sanders reentered the examining room to deliver her verdict. “I’m not sure your memory issues have to do with long COVID,” she said. The time that had elapsed between when Jennifer contracted COVID-19 and the onset of her brain fog was about 18 months; long COVID can persist for years after initial infection, but in Sanders’s experience, it “doesn’t usually reach out from years back to grab you,” she said. (It was possible, she conceded, that Jennifer had gotten a subsequent case of COVID-19 so mild she didn’t notice it.) More likely, the brain fog was due to fatigue, which was due in turn to chronic pain from the pinched nerve and the resulting disrupted sleep. And although Jennifer was out of shape, she did not have POTS. Sanders’s main recommendation was that Jennifer treat the

pinched nerve as soon as she could and then resolve to get more exercise, at least 30 minutes a day.

In real life, stories often fail to satisfy and mysteries are solved without a flourish or a gasp. “She didn’t say, ‘Oh, everything’s perfect,’” Jennifer said afterward. “It didn’t sound like I especially fit into the category of people experiencing long COVID.” Still, an answer is an answer — “and that did make me feel better,” she said.

By the time he saw Sanders, Christopher had already been diagnosed with long COVID and was desperate. A massive 58-year-old man with a round, boyish face, Christopher had been a bodybuilder and a carpenter for most of his life. “It used to be I could throw a 20-foot beam on my shoulders and walk up the ladder and put it in place, and now I can’t even pick it up,” he told Sanders. Phyllis, Christopher’s 87-year-old mother, was there too, sitting quietly by the door with a notebook and pen. Her memory was sharp, Christopher said with a rueful laugh, whereas his was disintegrating disturbingly. Formerly, he could quote lines and facts verbatim from books of popular biography and history, but now he can’t remember the paragraph he just read.

Christopher can no longer pay his bills and has had to apply for state mortgage assistance. Since his very brief, almost incidental bout with COVID-19 back in January 2021, Christopher has felt “huffy,” as if he can’t get sufficient oxygen to his organs or muscles. He has atrial fibrillation, a racing pulse that can escalate to 180 beats a minute. (In the doctor’s office, the physical therapist recorded his resting pulse as 126. Normal ranges from 60 to 100.) He gets extremely dizzy when he stands up. He has pain in his back — “stenosis,” his mother reminded him — and joint pain. Nine months ago, he was diagnosed with type 2 diabetes, another disease associated with long COVID.

Christopher has seen 19 doctors and specialists and been put through countless tests. He is on metformin, Jardiance, and Ozempic for his diabetes and a beta-blocker for his AFib. A neurologist at Yale prescribed a combination treatment of guanfacine, an ADHD drug, and NAC, an amino acid, which had been shown in a small trial to improve brain fog in long-COVID patients. Christopher believes these drugs have had little to no effect, but he continues to take them just in case. A pulmonologist had put him on Mestinon, normally used to treat a chronic autoimmune neuromuscular disease called myasthenia gravis, and though that gave him a little energy boost, he stopped taking it because of its side effects. “It was like someone had eggbeaters in my stomach all day,” he told Sanders.

As a young physician, Sanders put her faith in her tenacity and intrepidity. “The doctor must don her deerstalker cap,” she wrote, “and unravel the mystery.” The line was straight

and clear. Symptoms: beginning. Diagnosis: middle. Treatment: end. And even if the endings of her stories were not happy, as in a terminal prognosis, they were, at least from a narrative point of view, complete. But in the long-COVID clinic, diagnosis is the last thing Sanders knows with any degree of certainty. The middle and end are obscure. A chronic illness is not a satisfying story. It hardly qualifies as a story at all.

COVID-19 becomes long COVID in about 10 percent of cases, and scientists don't know why. Growing evidence suggests that the virus (or fragments of it) hangs around in "reservoirs" in organ tissue for a very long time. So the virus itself could be causing symptoms, or it may be triggering an autoimmune response, in the same way that Epstein-Barr virus is thought to activate multiple sclerosis, for example. Or COVID-19 may activate latent viruses, like EBV, that can sleep for decades in the body and wake up to cause symptoms. Or symptoms may be caused by inflammation. Lab mice infected with a mild case of COVID-19 get minor inflammation in the lungs but "significant damage in the brain," said Iwasaki.

These hypothetical causes, or triggers, may not be mutually exclusive. They may be cascading, overlapping, or bespoke: Long COVID may articulate itself differently depending on the environment within each host. But until researchers can develop targeted treatments, Sanders has to discover, prescribe, and suggest the unsophisticated solutions that exist. That's why she was thrilled, in the way of a nerd, or a fan, when in July, the Irish health service released a 173-page report dryly called "Interventions to Improve Long COVID Symptoms: A Systematic Review." It compiled and evaluated 57 tested medical treatments. Most were small unreplicated studies. In many cases, safety had not been gauged, and "no definitively effective treatments were identified." Still, here was something Sanders could use as a road map. She took 15 pages of notes.

She is constantly weighing her obligation to practice evidence-based medicine against a reality in which there is no evidence. "I'm out here in the ether where nobody knows nothing," she says. So although some doctors are using a combination therapy of powerful blood thinners and anti-platelet medications to treat the micro-clots common in long COVID, she thinks twice: "These medications have huge potential risks. If a person taking these drugs fell off their bicycle, they could die." Sanders sends as many patients as she can to a Yale colleague conducting a clinical test on the efficacy of a 15-day course of Paxlovid on long COVID, and she sometimes prescribes a low dose of naltrexone, approved for addiction disorders but frequently used off-label to treat chronic pain.

But mostly, she is swimming in the same sea of unproven options as her patients. "People will try literally everything," said Lisa McCorkell, co-founder of the Patient-Led Research

Collaborative, who has had long COVID since March 2020. “The answer to the question ‘Are people trying this?’ is ‘yes.’” Sometimes Sanders will prescribe a course of hyperbaric oxygen therapy — two hours a day, five days a week, for six to eight weeks, in a pressurized chamber of pure oxygen. A promising study has shown improvements for brain fog, though it’s not clear how long they last. She is intrigued by the utility of certain supplements, such as alpha-lipoic acid, which in combination with coenzyme Q10 may boost energy, and quercetin, which may have an anti-inflammatory effect. She is more willing than she has ever been to let patients drive the treatment, in one case giving a man with extreme insomnia an underutilized antidepressant that has a side effect of sleepiness, together with the suggestion that he buy some weed gummies. The riskiest treatment she has tried was to refer a patient to a surgeon to perform a stellate-ganglion injection; the patient had read on her Facebook group that it might restore her sense of smell. If the treatments are safe, Sanders is inclined to take a can’t-hurt, might-help stance. The insomniac started to sleep again, and the woman smelled coffee for the first time after her procedure. “These are anecdotes of one,” Sanders warns.

But Christopher was at the end of his rope, and Sanders was inclined not to fiddle. The first thing she tackled was his sleep. She refers almost every patient out to test for sleep apnea and has been astonished at how many come up positive. In any case, a patient may have brain fog owing to long COVID or poor sleep — or both — but if she addresses the sleep, she might fix the brain fog, and even if she doesn’t, she might fix the sleep.

Then Sanders prescribed something for his POTS. Christopher is not getting enough blood to his organs. As she explained it to him, when healthy people go from sitting to standing, the blood that collects in their middle in an area called the splanchnic (she loves saying *splanchnic*) immediately moves upward to the heart and brain. But in his case, that mechanism is broken, creating dizziness, breathlessness, and brain fog. She offered Christopher the simplest of solutions: prescription compression stockings, which she called “garments” to soothe his masculine pride but which she told his mother are like the strongest control-top pantyhose in the world. Thirty to 40 milliliters of mercury in pressure, constantly, in the legs and abdomen. Sanders said she believes the stockings, which she later concedes are “primitive” and “not elegant,” will make him feel better almost instantly.

The clinic currently shares space with Yale’s wound-care team — its patients inhabit a waiting room with people healing from gunshots and dog bites — but it’s scheduled to move to new, bigger digs in October. Sanders hopes to eventually expand the clinic’s mandate to include patients of all longtail infections and to make the case to Yale that it’s worth supporting long term. This would, in a small way, be an upheaval of the medical hierarchy, in which internists are among the lowest paid because what they do for a living is

not to intubate or operate or extract but to listen, ask questions, and advise. “Super-success” for Sanders would be to be succeeded in the clinic by a team of young, ambitious doctors who can find the same satisfaction that she does in uncertainty: “At the end of every appointment, every doctor has to ask, *What am I going to do for this patient — today — to make it better?* It’s a more nuanced question, and the answers come from a not totally absolute sense that you know what to do.”

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