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REFERÊNCIA

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How to become a health intellectual: the necessary *illusio* and its torments

Como se tornar um intelectual da saúde: a *illusio* necessária e seus tormentos

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Abstract

This test employs the theoretical framework of Pierre Bourdieu, central author to the description of scientific practice as a heuristic artifice to obtain a hermeneutic understanding of the meaning of collective health undergraduate studies in the context of the field of health, and trying to explain if the formation of the neo-hygienist approach can enable undergraduates in collective health to incorporate the *illusio* necessary (but not sufficient) to transform health in Brazil. This is an essay that discusses how social thought, through courses of humanities and social sciences, was historically introduced in the field of health. In this process, we will discuss how these courses form the common thinking of the so-called collective health and therefore start to incorporate the habitus of the professionals in the field. Finally, we will discuss how the acceptance of the initial pact by professionals with the rules of the field and of the symbolic forms of their legitimacy could occur and how the recently graduated professionals in collective health would accept the unspoken and implied rules of acting in this field. We observed that the symbolic domination of the clinic is still apparently unshaken and that the training of students in an area that should challenge this oneness of thought seems to keep intact this hegemony, despite the avowed goals of creation of this undergraduate course.
Keywords: Social Sciences; Public Health; Education; *Habitus*; *Illusio.*

Resumo

Este ensaio emprega o arcabouço teórico de Pierre Bourdieu, autor fundamental para a descrição da prática científica, como estratagema heurístico para se obter uma compreensão hermenêutica do significado da graduação em saúde coletiva no contexto do campo da saúde, e tentar explicar se a formação do neo-higienista consegue possibilitar que os alunos de graduação em saúde coletiva incorporem a *illusio* necessária – mas não suficiente – para se transformar a saúde no Brasil. Trata-se de um ensaio que discute como a forma como o pensamento social, por meio de disciplinas das ciências humanas e sociais, introduziu-se historicamente no campo da saúde. Nesse processo, comenta-se como essas disciplinas formam o fundo de pensamento comum da chamada saúde coletiva e assim passam a incorporar o *habitus* dos profissionais da área. Por fim, discutimos como a aceitação do pacto inicial dos profissionais com as regras do campo e das formas simbólicas de sua legitimação poderia ocorrer e como os novos graduandos em saúde coletiva passariam a aceitar as regras tácitas e implícitas de atuação nesse campo. Constata-se o fato de que a dominação simbólica da clínica continua aparentemente inabalada e a formação de alunos em uma área que deveria contestar essa unicidade de pensamento parece manter intacta essa hegemonia, a despeito dos objetivos confessos da criação dessa graduação.
Palavras-chave: Ciências Sociais; Saúde Coletiva; Educação; *Habitus*; *Illusio*

Introduction

A recent bet among the deans of collective health, started with more visibility and concreteness in the 7th Brazilian Congress of Collective Health happened at the University of Brasília (UnB) in 2003, was the encouragement of the creation of a undergraduate course of collective health. The realization of this idea won materiality in July 2008 at the same university, in the wake of the restructuring and expansion of federal universities (Reuni), with the first class of students who sought the title of bachelor in collective health.

This culmination represents a relative autonomy of the area, a new historical moment whose results are still to be clarified in the history of Brazil's public health. For this reason, in this essay, we seek to understand the close relationship between social thinking in health – generally represented by the social sciences (but not limited to them) – and the construction of this new field, and even more so, with the construction of mental and subjective provisions of the trained professionals. Translated in conceptual terms, which are the *habitus* and the *illusio* that will govern the subjectivity and the practices of future professionals, and how will they be systematically reproduced?

Using the theoretical concepts of Pierre Bourdieu (1996; 1980), we will try to examine the conceptual assumptions that are the bases of this process (in a foucauldian, episteme or device) of rationality construction of the area itself, incorporated or not in their future social agents. The attempt made here is to point out an ideal type if social agent (still hypothetical), named neo-hygienist (for the time being, sanitarist), outcome of the history of the field and responsible for the future reproduction of this social space.

Social thinking in health

Social thinking has a long history and shifting borders. Since the first studies on the living conditions of workers (Engels, 2008) at the dawn of capitalism until the specific, clear and decisive insertion of authors from humanities in the health field, many

years have gone by. Montagner (2008) attempted a systematization of the elsewhere ideal type, which point out the dilemmas of humanities and social sciences in health, particularly sociology of health.

We can understand the inclusion of disciplines that deal with society as a historical process of rationalization of a broader social thinking around a specific object and particularly within a specific field, the field of health. We blatantly employ here the concept coined and perfected by Bourdieu (1996), which defines a social field as a specific area of Western societies, built throughout history, with the initial contribution of the founders and later by agents that regulate the internal ordering of the field, in which the internal legitimacy, i.e,. its logical principle and explanatory principle of domination , is located, idiosyncratically and relatively autonomous in relation to a broader society. It is worth stating that this principle of hegemony is the source of the legitimate domination of the field and assumes a relative autonomy of the inserted agents, even if autonomy is relative and *in germe*.

This weberian process of rationalization of modern societies, in particular regarding the uses of the body and the control of society upon it, went through extensive and structural social changes, which gave to the field of healing a historic and clear place within capitalist and Western societies.

What would then be the logic of the legitimation of the field of health?

There is no simple or complete answer, but the ideal type that applies is that of domination by the clinic. Although the matter is polemic, the structure of the foundation is still based on healing capabilities, i.e., on the epistemological power of obtaining the cure allied with the medical tradition. If, at a given moment, the hegemony of biology was clearly established with the pasteurian revolution and with his “to each disease, its germ” axiom, its practical and objective confirmation occurred with the discovery of antibiotics that put into practice the pasteurian project of universal healing. With the advent of antibiotics, we went on to the utopian period of eradication of diseases. This project, perfectly adjusted to the wider enlightenment project, populated the minds of health intellectuals for a long time.

At the dawn of the Modern Age, in the late 1960s, with the deep social transformations, the exhaustion of utopian energies (Habermas, 1987), the new production arrays, and the questions to the enlightenment project, a new, more specific and more instrumentalized role was reserved for social thinking in health, developed specifically on the Brazilian social arena.

Limits of healing and the advent of postmodernity

The enlightenment project, aligned with the thought of Adorno and Horkheimer (1985), was based on the so-called instrumental reason and on the application of rationalities into the enchanted world of pre-capitalism. This unfinished project loses strength and shows its limits after the mid-20th century, from the unexpected results of the systematic use of reason.

The consequences of the second World War showed with clarity the mass genocide occurred during the two wars and also the systematic or systemic way of the rationality of destruction. The world that emerged from this process was born old and tried to make an effort of correcting the barbarism and inequalities with the proposal of the welfare State, which countered the classic liberal State. Despite its virtues, the welfare State was restricted to a small group of European countries, which put on their agenda the concern for the health of the whole population, through universal health systems.

In our historical reality, the process of rationalization of the field of health went through various stages or moments very well documented by various authors. The universalization of health care by the Brazilian State happened very late, in the 1980s, at the time of the country’s redemocratization and approval of a new Constitution, in 1988. Inside the movement for democratization, the sanitary movement was constituted as the spearhead of organizations of people, institutions and users for obtaining the right to health.

Through where did the social thinking in public or collective health walk?

The social sciences, traditionally, tend to be more urgent and necessary in times of great social change or significant changes in the social structure. In Brazil, the period of political polarization that preceded the military coup of 1964 and later the redemocratization were periods in which politics walked side by side with great social changes – both in the local scope, with the Brazilian industrial development and accelerated urbanization, and concerning the world crisis of taylor capitalism and its replacement by the toyotist model of production of goods, as well as the advent of the so-called financial capitalism.

During this period, with the political repression and the transformation of the public space, a good part of the intellectuals linked to leftist movements saw the restriction of their performance spaces and opted to enter and operate within universities. Universities came from a significant reform in 1968 and provided new knowledge branches and new spaces. With the end of fixed professorships and some flexibilization of higher education, many new professionals were incorporated. In the field of health, a good number of intellectuals linked to left-wing parties, notably the Communist Party, entered the University. In this sense, some institutions, like the University of Campinas (Unicamp), lodged people with very specific social interests, who saw health as an important area for political action. Likewise, health was a growing social problem, with expanding urbanization requiring a larger apparatus in the provision of health care. At the same time, as the social question, health was a fully justified heuristic means of militancy, and many Marxist thinkers held to it.

Despite the inclusion of some social scientists having started within a (American-born) functionalist line on health, as early as the 1940s and 1950s – which allowed the hiring, especially, of anthropologists in some institutions and departments of public health in Brazil –, the massive entrance and the development of critical and disruptive thinking in health only gained scale in the 1960s and early 1970s, specifically in the departments of preventive medicine in the schools of medical sciences or health. An exemplary case is that of the Preventive and Social Medicine Department of Unicamp, of the University of São Paulo (USP), among others.

This progressive insertion releases and authorizes an increasing production of a more politicized social health thinking, macrostructurally-oriented, with emphasis on the material aspects of illness and of extra-clinical determinations of illness – in short, insertion of the Marxist thought in health. It is a consensus that the Marxist thought and its emphasis on social transformation had a fundamental role in the gradual politicization of health in Brazil.

The key milestone of this insertion was the network of researchers and thinkers established by Juan César García. Argentine physician and sociologist, connected to the Pan American Health Organization (PAHO), he was a Marxist thinker who had a key role in the creation of networks throughout Latin America to discuss health in theoretical and practical terms, within the framework of critical thinking. In a posthumous work, García accurately presented social thinking in health, showing the various aspects of what would form, in his opinion, the field of social medicine, social sciences applied to health or social sciences in health: all receiving contributions from disciplines such as medical sociology, social sciences, medical economics, political economy of health, in addition to social epidemiology or hygiene (García, 1986). This presentation, in good time, shows an effort and recognition of a recently created field, but already in full production. This process is named by García of disciplinarization, beginning after World War II, having as main focus the departments of preventive and social medicine, where the first social scientists entered the medical field to deal with education. García has influenced various Brazilian and Latin American health professionals and intellectuals, and left sunken in his indelible print on the face of the field, even if still not adequately recognized.

This birth comes from the Meeting of Cuenca in 1972, in Ecuador, which brought together a group of thinkers around a social health proposal contrary to the current functionalism. That meeting, in García's reading, consolidated a knowledge area and enabled

the creation of the first graduation programs in the new subject.

We can summarize this process of birth of the field as the establishment of the central issue of class inequalities at the heart of the field of health thinking, especially in the 1970s.

Another milestone was the inevitable dissemination and assimilation of the contribution of Asa Cristina Laurell, in the epidemiological line, sculpting the concept of "health-disease process" having the so-called social medicine as the central work that illuminates the collective works of the field (Laurell, 1983). The author belongs to the pioneer center at the Autonomous University of Mexico, in Xochimilco, where one of the first graduation programs in social medicine was created.

Maria Cecília Donnangelo worked in this critical environment, within USP School of Thought, applying Marxist and local thought to the field of health. This field, then, began to be inserted within the worldwide productive structure and within the relative position of the Brazilian society in the context of production of wealth. The question she poses regards the role of health within the peripherical capitalist production (Donnangelo; Pereira, 1976). Likewise, she elucidates the role of physicians in this society and the characteristics of their work (Donnangelo, 1975).

Since those early days, social thinking became the basis of action, of epistemological explanation, and of political legitimacy of this field of knowledge. What happened was what Weber would call substantiation of a field's legitimacy. In this case, three lines of legitimacy: knowledge (epistemological), action (revolutionary and/or critic), and ideological legitimacy (political). In short, social thinking in health has long been basing the field of public (collective) health in Brazil, and it is rooted in it in such a way that it has become the common ground all that are inserted in it, consciously or not, recognizing this fact or denying it.

Epistemological changes

In the 1990s, the concept of vulnerability begins to be considered as a way of pointing to social causes of illness, and not to the victim or social groups at risk. The attempt was to overcome the concept of social inequality founded only on class structure, pointing to aspects beyond economy per se. The "resources" that can be used by individuals in their strategies to deal with their vulnerability are listed.

However, what gradually impregnated the field of health was the concept of risk, which is based on the concept of world as a probability space. The regularities in the world apply to human health, or, causality could be inferred collectively from the point of view of an entire population or species. This point of view embraces the positivist conception of world, in the sense that social structure regularities would consistently and significantly interfere in the illness of collectivities, even if the occurrences materialize on the individual level.

A recent phenomenon is the introduction of the idea that the specificity of the concrete situation interferes more imperiously in the illness, overdetermining the specificities of individual or group biology. In fact, we can replace the concept of specificity for "quality", which refers to a situation closer to a historical and situational assessment of health conditions. This means to say that we should seek the genealogy of a given situation, both in the historical and epistemological fields. This genetic and structural analysis leads us to replace the concept of risk by the gestalt concept of situation, i.e., to place a current concept, the concept of vulnerability.

This latest approach clearly points to factors or other casualties linked to symbolic aspects of the social situation (Kowarick, 2003). Before the discussion in the field of social sciences of this concept, professionals worked consistently with the concept of marginality, especially marginality in relation to the Brazilian production development, or rather, the insertion of people in the process of modernization of our peripherical capitalism at the time. The central ideas followed the discussion of Dependency Theory, a theoretical concept proposed by Fernando Henrique Cardoso and Enzo Faletto, that, within Marxist thought, sought to understand Brazil's unique situation in the world capitalist order. The discussion of the marginality of significant portions

of our population was important, but later replaced by more modern concepts:

> The question of marginality emerges with a Latin American discussion in the 1960s, 1970s, due to the characteristics of our urbanization process. [...] Even though formal work in Brazil has exceeded informal work for the first time, yet there is a huge amount of people on the margins of the production system. But no one else taks about marginality, no one else. In fact, I think I helped people not to speak of marginality anymore, you see? You can discuss this again, if it is, if it is not. It is an endless discussion. Deep down, it is almost an exegetical reading of Marx, of the *Grundrisse*, and of *The Capital*, anyway. And the themes go on. In this sense, the concept of vulnerability is wider, I mean, it is not just the question of insertion in the job market, it is also related to social bonds, social inclusion, institutions that aggregate the people at the local level, participation of these people in these religious institutions, anyway, any type of association. Regarding the concept of marginality, it is able to capture a wider dimension of social life (Kowarick, 2011, p. 241-242).

Vulnerability is a broader field of social thinking, which was made possible thanks to a certain exhaustion of the Marxist hegemony as the instrumental of leftist thinking. When we think of other forms of social analysis, in particular of social domination, new possibilities open up, both theoretical and methodological. The employment and engagement by social theorists of new perspectives brought up new techniques and new methods, both to traditional social thinking and to the field of health.

This change could be called epistemological turn, of qualitative nature. From the 1980s and early 1990s, authors with various influences began to guide the Brazilian theoretical agenda, with a delay of decades. Foucault, Elias, Bourdieu, post-modern philosophers and many others began to be systematically used. The theories of globalization and worldilization became very popular.

State of the art

Roughly speaking, the success of social thinking in health and its wide use as a perspective led to a distortion of its origins and representativeness. It is important to say that its success moved away from its origins linked to social sciences and humanities, with the risks inherent to this process. This success was noticed by some social scientists in the field of health as a lack of methodological and also conceptual rigor, "vulgarizing" social thinking, sometimes superficially. Several other authors have been working with this contradiction.

Having managed to become widespread and one of the foundations of collective health (even though underestimated or subsumed), the influence and action of social scientists would happen in what contexts?

A traditional role occupied by the social sciences and humanities has always been the formation of new frameworks, either regarding theoretical discussion or methodological training. One way to ascertain this role is to understand the role of social thinking in health in the training of new professionals for the area, now retroactive to the moment of graduation.

The education system as a breeding space of domination

The education system has a key role in the formation of new members of society, in particular in the conformation of the *habitus* of social agents. In the bourdieusian line of thinking, family is responsible for the primary *habitus* and the school system for the secondary. That is, the primary socialization is very attached to family and the secondary socialization is much influenced by school, especially in modern societies. For Bourdieu (1980, 1996), the school system has the double function of conforming the class and stationary *habitus* and also put to the test (to the heirs and the disinherited of the social distribution of society's wealth), the skills and provisions of excellence built during successive

socializations of the social agents. Thus, the heirs and well-born people need to legitimize, through the educational system, their right to the social inheritance. For the author, in modern societies, there is a retranslation of domination through the transformation of inequalities in school certifications. This retranslation has as a basis the denial of social, cultural and economic capitals, transforming them into an acceptable natural order (in many cases a professional hierarchy) through the use of symbolic violence.

The same happens in Brazil and in the field of health. Undergraduate courses have the role, through the final diploma, of "validating" the class *habitus* in order to legitimize a more or less valued position in the social world, in particular in the dimension of work and distribution of the best workplaces.

The function of legitimation is not direct, but happens by means of symbolic classifications, transmutation of symbolic capital linked to class and/or stationary *habitus* in valuations of occupations and professions, translated in degrees and in the symbolic valuation of those who graduated in the program.

This symbolic process of classification, i.e., this symbolic struggle between social agents for a better classification of their abilities and dispositions, built during their stay in the educational system, notably the University, is a historical and social process.

Thus, it is worth to try to advance some hypotheses regarding this new training in collective health, the bachelor's degree in the field. Our hypotheses are the fruit of the experience of construction of the first undergraduate program deployed in Brazil, at the University of Brasília, in July 2008. As professors in charge of building the curriculum and later as coordinators of this program during its deployment, we can infer some notions that will be discussed here.

Collective health undergraduate program: forming the *illusio* from the humanities and social sciences

A first finding is linked to the origin and selection of the new students of these new undergraduate programs. As a rule, the entrance exams select students who arrive at the University in the final stage of adolescence, time of consolidation of their identity. They are at the moment of transition from the secondary *habitus* to adulthood. Professional formation indicates a choice for professions linked to the ruling classes, which in Brazil always possesses higher education degrees. However, with the recent expansion of the higher education system, there was, in the same way that happened in France in the 1960s, a devaluation of diplomas. In this extended system, with evening, alternative, innovative and other types of courses, diplomas are no longer a certainty of professional placement.

It is worth mentioning that, in the distribution of the most profitable and valued courses, there is a selection linked to social origin, through class *habitus*. Students of new courses, in particular in the one we work in, seem to come from disadvantaged groups of society and tend to possess a *habitus* that does not favor their insertion in the dominant class of the field, as pointed out by Jaisson (2002), to the case of choices within medical schools in France.

Another central point, in our view, the professional identity is marked by the undergraduate course. This course conforms the network of contacts and social capital. In addition, it also conforms the school capital (diploma) and the symbolic capital.

In the traditional training of professionals in collective health, the freshmen in the area had prior professional identities. From this identity, they built a new symbolic placement in the field of health. We observed that those who opted for the field of public/collective health, already had a

symbolic knowledge linked to their profession, often enriching this capability with a new "disposition" or ability, such as working with the collective characteristics of biomedical aspects *tout court.*

In this case, the partial indicators that we developed showed that the freshmen do not belong to the dominant strata of society. The advanced *campus* to which we belong introduced regional quotas in addition to ethnic/racial quotas (Montagner et al., 2010). The result was an improvement over the previous situation, but the access to higher education is still not balanced or egalitarian.

Beyond *habitus*

If the *habitus* conforms the choices of the freshmen, delimiting the universe of both objective and subjective possibilities, it also conforms a formation of a kind of specialization of this very *habitus*. In the various areas of society, in addition to ingress and immersion in a particular dimension of society, even more is required . Mere participation does not imply adhesion or collusion, or even belief in the validity of the bet. It is worth mentioning, among those who pass, are inserted and participate in a particular social field, not all are "converted" or seduced completely by the principle of legitimacy. This principle is the basic and necessary condition for a complete affinity between the social agent and the field in which this agent is inserted. This affinity translates the degree of incorporation of the principle that governs the game and the practices of a particular field. Beyond that, this subjective and objective adhesion reflects the possibility of being properly adjusted to the field and with the possibility of success in the intrinsic game to each field.

In this regard, Bourdieu defines the concept of *illusio*, a common base to everyone, a collective belief in the game:

> *Interface: Comunicação, Saúde e Educação* the struggles for the monopoly of the definition of legitimate cultural production mode contribute to continuously reproduce the belief in the game, the interest in the game and the stakes, the *illusio*, which are also the product (Bourdieu, 1996, p. 258).

This notion is fundamental to understand the extent of the commitment and of incorporation of symbolic rules and practices of an individual psyche, which promotes a deep insertion of the agent's subjectivity in the crucial and bloody fights in progress in a particular field. This subjective projection, synonym of libidinal investment in the Freudian sense of the term, can and should be the basis of the success or failure of agents after long mental efforts of identification (or systematic disgust) to the fundamental rules of the field. The *illusio* also presents an indicator of the force of the symbolic struggles and even the healthiness and autonomy of a particular field, given that:

> *Interface: Comunicação, Saúde e Educação* each field produces its specific form of *illusio*, in a sense of investment in the game that removes the agents from indifference and bends them over and positions them to operate the relevant distinctions from the point of view of the logic of the field, to distinguish what is *important* ("what I care about", interest, as opposed to "what is the same", indifferent) [...] Each field (religious, artistic, scientific, economic, etc.), through the particular form of regulation of the practices and representations imposed by them, provides to agents a legitimate form of realization of their desires, based on a particular form of *illusio* (Bourdieu, 1996, p. 258-259).

This libidinally invested relationship, gestaltic and rationally unplanned action, happens along a period of adaptation, knowledge, recognition, and immersion in a particular social field:

> *Interface: Comunicação, Saúde e Educação* this interested participation in the game is established on the conjunctural relationship between a *habitus* and a field, two historical institutions that have in common the fact of being inhabited (with some differences) by the same fundamental law - it is this very relationship. There is nothing common, therefore, in this emanation of a *human nature* that is commonly put under the notion of interest (Bourdieu, 1996, p. 258).

Habitus versus *Illusio*

The hypothesis defended here is that the predominant professional *habitus* in collective health comes from the undergraduate course, even though it gradually become hybrid and more aimed at the social-biomedical space. This tradition points to the fact that, in general, there is a basic and legitimate knowledge that comes from the original training, which would support the legitimacy of the professional in the field of collective health. This knowledge and practice works in support of the performances on the field, from the prestige and legitimacy of the agent's original training area.

What did happen with the neo-hygienists who started to graduate from 2008?

The main question is from where to extract and shape the *illusio* and provisions of *habitus* necessary for this new identity? Some problems arise.

Firstly, the neo-hygienists do not have a clear and precise identification with the professionals who trained them. This happens because the *habitus* of the professors has much of their original formation, whatever it is. Second, not all professors are completely trained in collective/public health, typically they have graduate degrees or specific specializations, which does not always cover all the areas that make up the field. As a result, when this occurs, the identification of neo-hygienists happens partially. Thirdly, there is a basic contradiction that will be solved in the medium term, with the replacement of the trainers by the new hygienists: contrary to what everyone wants - seeing themselves mirrored on their students - the graduating professional will have many disparate characteristics with the *habitus* that form them.

This happens because the neo-hygienist will have a more general and less in-depth on specific disciplinary knowledge training. A possible example: graduated professionals with political knowledge (with practical performance), but without the formation of political science, public policy management or another specificity.

Assuming adhesion to the field, which *illusio* will students carry to their graduation studies? With what knowledge? Will they become graduate students with identity linked to the field or a carries of a diploma, who can participate in civil service exams?

The arguments above are purposeful and aim to put under strong lights the dilemma of adhesion to the illusio of the field. If this occurs, which *illusio* will be formed?

Parti pris

In short, we tried to outline the possibilities of formation of an *illusio* in future professionals. However, what would the utopia be?

For those who genetically come from human and social sciences, which would be the role of these new professionals?

Regardless of the required technical training, this neo-hygenists, in our utopian vision, should and must be a health intellectual. Gramscian organic intellectuals, organizers of culture and strategic occupiers of institutional spaces of civil society and of the expanded State (Gramsci, 1978). Specific intellectual of Foucault, linked to a specific social issue and restricted to a field of historically determined knowledge (Foucault, 1979). Both and simultaneously.

For both, the incorporation of the *illusio* of the health and collective health field, along with theoretical and thinking instruments, based on the philosophical and sociological theories and concepts, is the central point. Assuming that the training will continue, the impregnation of this *illusio* is the central and most valuable task of social thinking in health - an inglorious task because it has been forgotten, gullible as subtle and largely subjective, denied and not materialized in numbers and indicators, however, and above all, essential.

Maybe the success of this endeavor will dictate the disappearance of the humanities and social sciences in health, because our knowledge would be part of the *habitus* of the new hygienists, and would go into oblivion of practicality as an internalized provision in the field of collective health and in the future naturalized reproduction.

In summary, the *illusio* that clearly incorporates the social sciences and humanities is and represents

the **intellectual** need of collective health, which we like to name neo-hygienist. Its construction (or non-construction) defines the game and the future of collective health, its reproduction as field and knowledge, in short, is a successful episteme.

References

ADORNO, T. W.; HORKHEIMER, M. *Dialética do esclarecimento*: fragmentos filosóficos. Rio de Janeiro: Jorge Zahar, 1985.

BOURDIEU, P. *As regras da arte*. São Paulo: Companhia das Letras, 1996.

BOURDIEU, P. *Le sens pratique*. Paris: Les Éditions de Minuit, 1980.

DONNANGELO, M. C. F. *Medicina e Sociedade*: o médico e seu mercado de trabalho. São Paulo: Pioneira, 1975.

DONNANGELO, M. C. F.; PEREIRA, L. *Saúde e Sociedade*. São Paulo: Duas Cidades, 1976.

ENGELS, F. *A situação da classe trabalhadora na Inglaterra*. São Paulo: Boitempo, 2008.

FOUCAULT, M. *Microfísica do poder*. Rio de Janeiro: Graal, 1979.

GARCÍA, J. C. Presentación. In: NUNES, E. D. (Org.). *Ciencias sociales y salud en la América Latina*. Montevideo: OPS-Ciesu, 1986. p. 19-29.

GRAMSCI, A. *Os intelectuais e a organização da cultura*. Rio de Janeiro: Civilização Brasileira, 1978.

HABERMAS, J. A nova intransparência: crise do estado de bem-estar social e o esgotamento das energias utópicas. *Novos Estudos Cebrap*, São Paulo, v. 18, p. 103-114, set. 1987.

JAISSON, M. La mort aurait-elle mauvais genre? La structure des spécialités médicales à l'épreuve de la morphologie sociale. *Actes de la Recherche en Sciences Sociales*, Paris, v. 143, n. 1, p. 44-52, 2002.

KOWARICK, L. Sobre a vulnerabilidade socioeconômica e civil: Estados Unidos, França e Brasil. *Revista Brasileira de Ciências Sociais*, São Paulo, v. 18, n. 51, p. 61-85, 2003.

KOWARICK, L.Vulnerabilidade e (sub)cidadania na sociedade brasileira: entrevista com Lúcio Kowarick. *Idéias: Revista do IFCH Unicamp*, Campinas, v. 1, n. 3, p. 237-252, 2011.

LAURELL, A. C. A saúde-doença como processo social. In: NUNES, E. D. (Org.). *Medicina social*: aspectos históricos e teóricos. São Paulo: Global, 1983.

MONTAGNER, M. A. Sociologia médica, sociologia da saúde ou medicina social? Um escorço comparativo entre França e Brasil. *Saúde e Sociedade*, São Paulo, v. 17, n. 2, p. 193-210, 2008.

MONTAGNER, M. A. et al. A graduação em saúde coletiva no Brasil: um estudo de caso da UnB – Ceilândia. *Saúde Coletiva*, Barueri, v. 7, n. 42, p. 167-172, 2010.

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