

About Science, History and Sociology: an interview with Ilana Löwy

Sobre Ciência, História e Sociologia:
uma entrevista com Ilana Löwy

Acerca de Ciencia, Historia y Sociología:
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Professor Ilana Löwy has worked for more than twenty years in different research projects in Brazil, mainly with Oswaldo Cruz Foundation (Fiocruz). She knows a lot about sciences and how it is put into practice in Brazil. Her background, as she will explain in the interview, is a mix between a scientist and a historian, with other layers added: philosopher of science and sociologist. But let her talk!



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Professor Ilana Löwy (Centre de Recherche Médecine, Sciences, Santé, Santé Mentale, Société, Paris, France).

Carvalho We thank you very much in the name of *Cadernos de Saúde Pública* for giving us this interview in spite of all the noise and all the problems we had to find a nice place to talk. Professor Löwy, can I call you Ilana? (...) Can you just give us a bit of your background and what, in general, you are involved with?

Löwy I was initially trained as a biologist and have a PhD in immunology. I was also interested in history, and as an undergraduate student I studied history of art in addition to science. At some point I became fascinated by history of science and social studies of science. I started my talk at Fiocruz with a quotation from a pioneer of sociology of science, Ludwik Fleck. I discovered Fleck's thought through a colleague who was a philosopher of science. When I first read his work, my reaction was: "Ah, this guy really understood what science is about". Other philosophers of science spoke about very abstract issues, but Fleck, who was an immunologist, explained how the kind of scientific research I was familiar with worked. It was a great discovery for me. I retrained as a historian of science, although how exactly I am defined depends on the place where I am.

Carvalho I understand that.

Löwy In France, many historians of science came to this discipline from philosophy. I have no philosophical training, therefore I cannot be a traditional French historian of science. For scholars trained in the French tradition I am a sociologist, because sociologists are people who do not really know anything.

Carvalho Or know bits of everything.

Löwy Yes. But I'm also a bad sociologist, because I do not do quantitative research. In Germany, I am an epistemologist, because they had read my work on Fleck. Fleck is well-known in Germany and is seen mainly as epistemologist. In England, I am an "internalist" historian of science because most of my work is grounded in a close reading of scientific materials. In the British tradition of history of science, an "externalist" historian of science reads documents such as birth and death records; data on urbanism, industrial development, nutrition and employment; information on state and municipal expenditures; maps and architects' plans, while an "internalist" historian of science reads scientists' writings. I mostly do the latter, and I also study articles, scientific archives and laboratory notebooks. I think in the United States I am just an ordinary historian of science and medicine, probably in Brazil too.

Carvalho I understand. But your background in biology makes it easier for you to understand scientists?

Löwy In some ways, yes, but it is complicated. I had this debate with Bruno Latour. When I was doing my transition from science to history of science, Latour, who was very helpful at that stage, once told me that knowing too much about the science I am studying may be a problem, because I might be too inclined to adopt scientists' point of view. This indeed may be true, but a failure to understand what exactly the scientists try to do may also be a problem. One should attempt to find the right balance. That is why my model was Fleck, who was 100% scientist but was still able to have an external view on science.

Carvalho And what are you doing here in Brazil?

Löwy It's a long story. I first came to Brazil because, twenty years ago, there was an agreement for scientific exchanges between Fiocruz and my home institution, INSERM [the French National Institute of Health and Medical Research]. Paulo Gadelha, who founded the Casa Oswaldo Cruz (COC), invited several historians from my department, including myself, to come to Fiocruz. At that time, I studied the history of the Pasteur Institute, and became interested in a group of scientists from Pasteur who came to Brazil in 1903 to study yellow fever. I looked for materials on these scientists, and on Brazilian researchers who collaborated with them, such as Oswaldo Cruz, or the director of Rio de Janeiro's isolation hospital, Carlos Seidel. I found rich archive materials in Rio, and ended up writing a book on the control of yellow fever in Brazil in the first half of 20th century. To write this book, I had to learn to read Portuguese and also acquire some understanding of Brazil's history. I developed collaborations with researchers from COC, then with other Brazilian researchers from Fernandes Figueira Institute and Social Medicine Institute of Rio de Janeiro State University (UERJ).

Carvalho It's a partnership for more than twenty years now.

Löwy A close partnership, yes. The formal exchanges between the Fiocruz-INSERM partnership ended in the early 21st century, but I continued to collaborate with many Brazilian researchers. I had numerous Brazilian students who came to Paris on exchange scholarship, especially before the economic crisis. I still have Brazilian students, but now they are mainly from the state of São Paulo because Fapesp [São Paulo Research Foundation] still has money; Faperj [Rio de Janeiro Research Foundation] has much less.

Carvalho And what are you studying in this visit?

Löwy After I published the book on yellow fever in 2000 [it was translated into Portuguese in 2006], I worked for many years on the history of cancer, mainly in France, UK and USA, but also in Brazil, especially by collaboration with Luiz Antônio Teixeira from COC. My current research is mostly about Brazilian science and medicine. My studies are focused on the relationships between the laboratory and the clinics, and in the role of medical/biomedical technologies. This topic is seldom studied in Brazil. Sociologists of medicine are interested in subjects such as patients' experiences or the effects of violence and poverty on health, and rarely examine medical technologies, while Brazilian scholars interested in technology rarely study medicine. I also investigate the intersections between biomedicine and gender. I recently finished a research on the history and present time practices of prenatal diagnosis. In the framework of this research, I compared prenatal diagnosis in Brazil and in France. Working on prenatal diagnosis, I became interested in the management of hereditary diseases in Brazil, and elaborated a project on this topic with a Brazilian colleague from UERJ, Marilena Corrêa. The project was then halted by the economic crisis.

Carvalho Political and economic crises.

Löwy Yes. In France too we suffer from the consequences of the economic crisis. We went from a high level of state funding for research to a very low level of such funding, especially for social sciences. At first, we were paralyzed by this development; then we learned to cope. One of the ways to cope was to look for other sources of funding: European money, non-governmental foundations' money, funding from international organizations. It is not perfect, but we muddle through.

Carvalho We need to find solutions.

Löwy Looking for external sources works! Funding for the genetics project was halted by the UERJ crisis, but we decided to do it anyway. In the meantime, an English researcher from University College London who was interested in the same topic, Sahra Gibbon, obtained money from the Wellcome foundation for an akin project: this made it possible for us to start fieldwork. In the framework

of this project, I'm looking at the use of new biomedical technologies employed to diagnose hereditary diseases, especially to avoid the birth of affected children. In Brazil there are two problems with diagnosis of hereditary conditions: paucity of means and the criminalization of abortion. In countries in which abortion is legal and people have access to good quality health care, technology can help individuals from families with a hereditary disease to have healthy children. If a woman knows that she is at high risk to have a child with a hereditary condition, she can undergo an early prenatal diagnosis and abort an affected fetus. Couples at risk of such disease can also undergo preimplantation genetic diagnosis: after in-vitro fertilization (IVF), researchers analyze the embryos produced in a test tube, and implant in the woman's womb only those without the harmful mutation. Abortion is illegal in Brazil, while IVF and preimplantation genetic diagnosis is very expensive. The majority of people aware of the presence of a hereditary disease in their family have very limited reproductive choices: usually they only can decide whether they will have biological children.

I recently investigated screening for hereditary diseases in Israel, where the situation is very different. The State funds population-wide testing for the prenatal diagnosis of selected hereditary diseases, and preimplantation genetic diagnosis. Every family in Israel at risk of having a child with one of the hereditary diseases on the government's list has the right to make as many IVF cycles as necessary (within the limits of the woman's fertility), until they have two disease-free children.

Carvalho It is crazy, isn't it?

Löwy It is only for selected, severe hereditary conditions. Everybody shouts: "*Eugenics! Eugenics!*" "*People will use preimplantation genetic diagnosis to select children with blue eyes!*". But this does not happen in practice. Preimplantation genetic diagnosis is only employed to allow the birth of a child free of a hereditary pathology.

Carvalho It is clearer now.

Löwy We can talk a little about this. I think this eugenics argument is a straw man. I never saw a couple who want to go through the extremely stressful and difficult process of IVF and preimplantation diagnosis just to have a child who has curly hair, plays basketball well, or have an IQ over 130. Couples do it only when they are at risk of having a very sick child. In Israel this approach is available only to prevent the birth of children with a very serious inborn condition. I am not an unconditional admirer of Israeli policy in the domain of population genetics; I agree with some aspects of this policy and disagree with others. I am, however, sympathetic to the idea that it is not fair that only affluent people can have access to new genetic technologies. This is exactly what happens in Brazil. The possibility to prevent a birth of a child with hereditary condition present in the family depends on the couple's income, often because of the thorny issue of abortion.

Carvalho And what do you know about abortion, have you studied in Brazil?

Löwy All my knowledge on this topic is indirect, from the work of scholars such as Debora Diniz, Marilena Corrêa, Simone Diniz, Cecilia McCallum and Silvia de Zordo.

Carvalho You know who knows.

Löwy I know who knows, exactly.

Carvalho And what about Zika, how did it come...

Löwy Mostly by chance. My plan was, as I explained earlier, to study hereditary diseases. Then, in the middle of the preparations to start this study, Brazil was hit by Zika epidemics. I was contacted by colleagues who told me: "*You worked on the history of the efforts to eliminate Aedes aegypti from Brazil, then you studied birth defects in Brazil. You are in an especially good position to study the Zika epidemics*". I first joined a research group, ZIKAlliance, funded by the European Union; then in collaboration with UK colleagues, we also obtained UK money to study Zika epidemics from the social sciences point of view.

Carvalho I never knew you, because I'm a hardcore scientist, but the first time I saw something from you, it was an interview about Zika and abortion discussing how abortion for rubella was accepted and the position of French and British doctors then, who would support the women, and then discussing a bit the position of Brazilian doctors now.

Löwy In the 1950s and 1960s abortion was illegal in France and in the UK. Nevertheless, many French and British doctors from the public sector provided abortions to women who were infected with rubella when pregnant and wished to interrupt their pregnancy. Brazilian doctors did not provide similar services during the Zika epidemics. My hypothesis is that there are two reasons for this

difference. One is that professional attitudes of obstetricians and fetal medicine experts in Brazil are shaped by the criminalization of abortion. In the 1950s and 1960s, prenatal diagnosis did not exist. Doctors provided abortions to women infected with rubella because of the risk of a fetal malformation, not a certainty of its existence. Today physicians can know many things about the fetus, but in Brazil they have a limited ability to act on this knowledge, at least legally. The second possible reason for the different attitude of Brazilian doctors is the existence of the sharp division between the Brazilian Unified National Health System (SUS) and the private health sector.

Let's speak about the role of criminalization of abortion first. When I started my comparative research on fetal pathology, I thought that the main difference between French and Brazilian pathology services was that French doctors were resource-rich and Brazilian doctors were resource-poor. Then I found out that this was not accurate. In France too pathologists complain about insufficient resources. In Brazil, pathologists who do not have enough money for specialized laboratory equipment sometimes use recycled Kibon ice cream boxes to stock tissue samples. In France they use cheap plastic boxes bought in the supermarket. This is not an important difference. The big difference between France and Brazil is the density of collaborative networks. Pathologists in both countries use similar instruments and approaches, but there is one device which they use much more often in France than in Brazil: a mobile phone.

Carvalho Pathologists use more often their mobile phones in France.

Löwy Much more, for their work. If they have a problem, they immediately call somebody, since they have this very dense network. A pathologist takes a photo of an organ or a microscope preparation she is studying and calls a colleague in Marseille or Lyon and asks her: *"I have a problem with this sample, what do you think is going on here?"*

Carvalho But is this formally organized?

Löwy Of course not!

Carvalho It is informal.

Löwy It is mostly informal, but extremely dense.

Carvalho That is interesting.

Löwy Zika epidemics in Brazil created similar dense collaborative networks, but this is for research, not for a routine diagnosis. In France, pathologists in a teaching hospital I observed have a staff every day, each day of the week, with a different group of specialists: geneticists, obstetricians, pediatricians, fetal medicine experts. Staff meetings discuss complicated cases. Sometimes such a case is discussed by three or four groups of specialists, not infrequently during the same week. In Brazil, the frequency of staff meetings that discuss abnormal fetal development is much lower. My guess is that this happens because in Brazil it is less important to produce a precise diagnosis of fetal anomalies. If a fetal medicine expert makes a mistake in France, it is perceived as a disaster. It is a disaster for the woman, because she may abort a healthy fetus or give birth to a severely impaired child against her wishes. It is also a disaster for her doctor, not so much because of the risk of a malpractice trial – such trials are relatively rare in France –, but because physicians feel bad when they make a professional mistake. Moreover, their colleagues will know that they made such a mistake.

Carvalho It is a form of social control.

Löwy Yes, exactly. And since nearly every abortion for a suspected fetal anomaly is followed by an autopsy and further investigations, doctors know rapidly how accurate their initial diagnosis was. Dense networks of specialists reduce the risk of errors. In addition, the collective production of diagnoses dilutes the responsibility for potential errors.

Carvalho So would you say that doctors in Brazil are more individualistic?

Löwy I do not think that they are more individualistic as people, but the legal and social framework in which they work does not encourage them to be fully responsible for the diagnoses they produce. If a Brazilian expert of fetal medicine who works in SUS makes a mistake, nothing happens, because, with very few exceptions, the woman cannot interrupt the pregnancy. Her doctors often tell her that her child will have health problems, but it is impossible to know precisely how severe these problems will be until the child is born. If their diagnosis is later found to be inaccurate, the argument *"we cannot know what the consequences of a fetal malformation observed during pregnancy will be"* legitimates their error, but also their lack of power to help women who do not wish to continue a pregnancy with a severely disabled child. A woman cannot sue a doctor, including one from the private sector, because

she or he made an error and deprived her of an opportunity to commit an illegal act. Moreover, if the woman diagnosed with a fetal impairment decides to have an abortion, the doctor often has no way to learn how accurate her/his diagnosis was, since there are no autopsies of illegally aborted fetuses. As a consequence, Brazil has a weaker social and professional control of the quality of prenatal diagnoses.

The second problem is that physicians and users of SUS services do not belong to the same social class. Many Brazilian doctors are sincerely dedicated to SUS, but they don't use it themselves. I believe that the fact that middle-class people do not depend on SUS strongly affects the organization of health care in Brazil. Public hospitals in France have a mixed public. Some patients are poor and some are recent migrants, but middle and upper class people also use public hospitals because they often provide the best service. Not all the doctors who work in public hospitals are great egalitarians, and some have negative attitudes toward poor people, migrants or people with darker skin, but overall there is no sharp division between "us" (doctors) and "them" (patients). Physicians know that if they or members of their family will face a serious health problem, there are good chances that they will be treated in a hospital similar to one in which they work.

Carvalho It is a citizenship right.

Löwy Exactly.

Carvalho I have just submitted a paper with a student, she's a qualitative researcher, I think her Master's is in political science, and the discussion was on some interviews in Rio das Pedras *favela* [Brazilian slum]. The discussion is about people who use SUS, and people who try to... they all live in the same favela, and people hate SUS, because they say "*They don't respect me*" and they want to have someone who will take care of them, like the old kind of doctors who were benevolent, and then the other group says "*No, I want to pay and I want my right as a consumer*". So, it's a mess, I think.

Löwy I looked at the high-end clinics in Rio de Janeiro, and that is what people say there too. Some want a paternalist doctor who will tell them what to do, and some expect to be well treated because they pay a lot of money for the services they purchase. Such services may include an illegal, but reasonably safe abortion. In Brazil, women who have enough money usually can have an abortion in good conditions, while poor women use poor quality abortion clinics or take abortive drugs, sometimes in unsafe conditions.

Carvalho Illegal abortion is complicated. You can never guarantee that conditions are really good, even when it is supposed to be good.

Löwy That is true, but if a woman has enough money to go abroad, she will abort in good conditions. In the 1950s and 1960s, French and British women of all social classes who were infected with rubella during pregnancy could obtain an abortion in a public hospital. In France, doctors who were against abortion often told the woman "*I cannot provide an abortion, I am a Catholic, but you should see my colleague who is willing to do it*". In the Western Europe of the 1950s and 1960s, women infected with rubella often ended their pregnancy in a public hospital, because many French and British doctors saw access to abortion in these cases as a question of social justice.

Carvalho Yes, because it agrees with the idea of citizenship.

Löwy Yes, exactly. The anthropologist Emilia Sanabria, who studied the use of sex hormones as drugs in Bahia, argued that the sharp division between private sector and SUS in Brazil constructs two different kinds of citizenship. One kind of citizenship is constructed by a struggle for the "right to health"; it leads to the homogenization of health care. The other kind of citizenship is constructed as a freedom to have choices, and is grounded in the individualization of health services. It is not surprising that people from the favela revolt against being treated in a uniform and sometimes disparaging way, and that they want consumers' rights.

Carvalho That's what I was talking about...

Löwy Rich people believe that they are entitled to an individualized care.

Carvalho Sure. People in *favelas* want this as well. They want to be taken care of in a "human" – they say it's a "*human way*", a doctor who will let you sit down and look at you as a person. They do not want to be standardized, second-class citizens.

Löwy If the physicians who work in a hospital never consider the possibility that they, their parents or their children will use the services they provide, this hospital, in spite of the staff's undoubtedly sincere effort to provide competent and compassionate treatment, reproduces and reinforces the division between "us" and "them".

Carvalho True. And we have tax breaks when we use the private services. So the public budget is paying for us to use the private sector.

Löwy Progressive sociologists of medicine also use private health plans, and only rarely employ SUS services. It is a real problem. You cannot have inclusive systems for education and for health care if middle class, educated people...

Carvalho If middle class, educated people do not use it themselves. It is just a beneficent thing for the poor.

Löwy Some social scientists and also some activists praise the “*access to citizenship by a struggle for the right to health care*”, but middle class people do not access citizenship this way. Brazil has many wonderful patients’ associations, but often these associations fight for access to resources, as associations of parents of children with disabilities who fight for the right of their children to obtain expensive drugs for their disease via SUS. Many doctors support such activism. Doctors, as a rule, are sincerely committed to the well-being of their patients, and are distressed when they are unable to provide efficient cures. By contrast, I am not aware of the existence in Brazil of associations of patients that promote a critical view of the medical establishment, and tell doctors: “*we contest the way you treat us*”.

Carvalho Yes, I understand what you mean.

Löwy When the patients are always “them” because they live in a different world and use different services, it is difficult not to be patronizing, in spite of the good will of individuals – whether they are doctors or social scientists – who try to help the poor. Scholars who described a craft cooperative of women in a favela told me that “*this group is really so wonderful, these women organized themselves and did everything without external help*”, and I thought “*Oh, my. Why these women should not be able to take care of their problems? Women who live in a favela are probably much better at dealing with this kind of practical issues than those who live in Barra da Tijuca*”.

Carvalho I think that this is always the same kind of class divide and a beneficent kind of approach. And, as you said the last time we talked about it, social scientists in Brazil rarely study the private health system, or are interested in the rich.

Löwy Researchers who studied the health care of privileged social strata in Brazil often come from abroad. Scholars who come to Brazil for the first time are frequently stricken by the contrast between services for the poor and the rich. People who live in Brazil see it less. In addition, social sciences in Brazil have a strong tradition of studying the poor for a very good reason: misery is a big problem. But the huge gap between the rich and the poor is also a big problem.

Carvalho At the last talk you gave you presented a very interesting way of trying to understand the known unknowns. Can you develop a bit on that?

Löwy “Known unknowns”, or “public secrets”, are things that people know that exist, such as the division SUS/private sector, but do not want to talk about it. When I started to teach in Rio seven years ago, I showed students a photo of Manguinhos favela, sometimes called “*the Gaza Strip*”, because it looks like a war zone. Then I showed them a photo of the cutting-edge laboratories of Bio-Manguinhos, and I said “*This is Bio-Manguinhos and this is Manguinhos without the Bio*”, and the students said “*Oh, how interesting*”. They saw both every day, but failed to grasp that there may be something very disturbing in the fact that the most advanced research institute in Latin America faces a favela which is in such a terrible state. This contrast is a public secret. Obviously everybody knows that there is SUS and a private health sector, but people, including those who are sincerely devoted to SUS, elect not to dwell on the fact that people like them rarely, if ever, use SUS services.

Carvalho I remember when I was a medical student, many, many years ago, and I had a car accident, and people were asking me “*Where do we take you?*” and I said “*Any public emergency room*”, because in 1970 they were much, much better. I think this division is the other way around as well, because the only places that everybody would like to go in the public system are the universities. As soon as the quotas for poor and for African-Brazilians began to change the composition of the social class in the public universities, this put the privileged status of students of public universities at risk. This may be one of the reasons for the government’s recent proposal to abolish the rule that public universities are free, and introduce fees for the students.

Löwy Oh, gosh.

Carvalho Oh, gosh. I think it's related to the fact that middle class people do not want to coexist with the poor. A university might be one of the very rare places where people with very different social classes truly coexist.

Löwy But to pass the entrance examination to a public university, students usually have to go to private school; this perpetuates class segregation.

Carvalho With the new quotas program, it is beginning to change.

Löwy I heard there is now more social mixing in technical professions like engineering or computer science than in medicine.

Carvalho Yes, but it is changing.

Löwy I also heard that private medical schools have a more diverse student body, but these schools are very expensive; they also have a lower reputation than public medical schools. Students accepted to the latter, and who therefore have a better chance to join a medical elite, are mainly still from the upper social strata.

Carvalho I think so.

Löwy Going back to Zika, I listened to the researcher from Fiocruz in Recife, Celina Turchi, who played an important role in the display of causal links between Zika and microcephaly, and she said "*Zika is a disaster but also an opportunity*". It is indeed an opportunity, because Brazilian researchers can publish in prestigious scientific journals, and they became much more visible. This opportunity stimulates scientific collaborations and the construction of much denser networks. I saw some of the doctors who earlier mainly used their mobile phones to make personal calls suddenly start to use them all the time to ask colleagues for advice and help, schedule meetings and exchange information. Now the challenge is how to transform these networks, developed mainly to advance research in a period of febrile activity and international competition, into permanent structures that will benefit patients; not only patients with unusual and "interesting" diseases, but also those with more "banal" pathologies.

Carvalho I think this is the challenge.

Löwy There are several little studied aspects of the Zika epidemic in Brazil. One is the "disappearance" of Zika: there are nearly no new cases, and nobody knows for sure what will happen next. This provides a unique opportunity to study the waning of an epidemic. Or, as far as I know, not many people are interested in this topic. Another is the fate of the Zika epidemic among middle class women. Numerous studies of Zika-induced birth defects focus on poor, young, unmarried women in Recife. It may be interesting to trace the reactions to this epidemic among rich, older, married women in São Paulo. I am not aware of studies that investigated the means affluent women employed to protect themselves, followed what happened in cases in which a middle class pregnant woman became infected with Zika virus or examined other ways private health services dealt with the Zika threat. One of our students told us that, at the height of the Zika epidemic, some high-end private hospitals developed their own system of testing their blood supply for Zika virus, to ascertain that their patients would not be contaminated through blood transfusion. Another one are the problems linked with diagnostic uncertainty: there are no simple and inexpensive diagnostic tests for Zika. To understand the consequences of such uncertainty, one has to investigate diagnostic techniques: which diagnostic approaches were used in each site at a given time, how they were used and to which extent they were seen as reliable.

Carvalho And how do these elements translate to clinical practice?

Löwy Clinical or epidemiological practice. How do you collect data, what is the architecture of data, which data are included and which are excluded. So there is a really interesting research program here.

Carvalho Before just worrying about publishing this paper, or gathering this small tiny bit of knowledge, we need to think about the whole picture, not just the small bit each scientist is involved with. That's what I think was interesting in "*Zika from A to Z*", a seminar from last year. It was very interesting because for the first time I could really see people from very different areas trying to understand each other. Often we talk about interdisciplinarity and it's just talking, it's nothing true, and I think as well that Zika is really an opportunity to integrate very different kinds of minds and of questions.

Löwy Brazilian social scientists develop interesting research programs on Zika, but many of these programs are focused on well-defined questions, such as the patterns of coping of mothers of children with microcephaly. These are undoubtedly vital issues, but it may be also important to tackle “known unknowns”: difficult or problematic research topics, sometimes hidden in plain sight.

Carvalho Studies on problematic topics may be more difficult to publish, but it doesn’t matter. If they are meaningful questions, you need to address them. The main problem is not publishing, it’s looking for meaningful questions and solving them somehow.

Löwy Just identifying such questions may be very important...

Carvalho Just asking is half of the way.

Löwy Half of the way, exactly. The historian Carlo Ginzburg said that a good researcher should work “*against the grain*”, and become the devil’s advocate. If you really feel good about your research, thinking “*this is a great subject, I know exactly what should be done and how it should be done, and I am sure that this study will produce important results*”, maybe you have a problem.

Carvalho Yes, probably. If you feel comfortable, it’s not good science.

Löwy The anthropologist Didier Fassin argued that, in social sciences, uneasiness is a precondition of the production of good research.

Carvalho And in science in general. Yes, great. Well, closing remarks, do you want to say something else or open up some topic?

Löwy Well, I just want to say that it is great to work here.

Carvalho Oh, in the name of everybody, thank you.

Löwy I think Brazil is fascinating. It is sad, however, that the country was hit by such a severe political and economic crisis. When I started to teach in Rio, eight years ago, Brazil was the Promised Land. Europe was already hit by an economic crisis, and here new possibilities were opening up, everything was expanding, and people were very optimistic about the future. Brazil looked like a paradise. Now Brazil does not look like a paradise anymore, it looks like all the other countries that suffer from consequences of a crisis.

Carvalho Unfortunately.

Löwy Yes, but I still think it is a very good place for doing research, and also for the development of a critical social science. When scholars face serious political and economic difficulties and fight to defend SUS, universities and public services, they may be reluctant to tackle unsettling issues and say “*let’s concentrate on the positive, on our achievements, on the good things we do*”. I believe this is not the right attitude.

Carvalho Yes, we need to face...

Löwy Going through hard times may be even more important to investigate difficult subjects and avoid sweeping problems under the carpet.

Carvalho Yes. Thank you very much, *muito obrigada*.

Löwy *Obrigada a você*.

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