Producing Little Decision Makers and Goal Setters in the Age of the Obesity Crisis

Michael Gard

It is obviously possible to argue that education is always an arm of social policy. However, there are just as surely degrees of directness between the agendas of non-educational authorities and what happens in school and university classrooms. This article considers what appears to be a direct example of a particular public policy agenda, the so-called “war on obesity,” translated into curriculum. My intention is to rouse the field from its slumber and to ask whether we are content for others to decide what and how we will teach health and physical education in schools and universities. I do this by examining a specific example of health and physical education curriculum. However, this is not a call for resistance to the intrusion of outsiders; we always need to listen to others. My question is whether the voice of physical educators matters at all when it comes to the practice of physical education.

A contradiction lies at the heart of most elaborations of liberal educational discourse. On the one hand we have the idea of education, as Dewey (1938) might have put it, concerned with experience, growth, experimentation, and transaction with the world. Although often expressed in different ways, this idea holds that children are endowed with a range of talents and potentialities that educators are charged with the responsibility of developing. On the other hand is the inescapable truth that education involves a curtailing of possibilities and that choices about curriculum goals, content, and delivery must be made. Even in educational contexts that purport to be “student centered,” students are still offered a less than limitless range of choices.

One way of distinguishing between different approaches to educating children, although not one that is often discussed, is to consider the extent to which rhetoric matches lived classroom experience. For example, although it is always risky to leap to conclusions about what is really going on in classrooms, imagine a classroom teacher who insists the she and only she knows best about what, when, and how children should be taught and then uses an interpersonally authoritarian style to offer children highly prescribed curriculum content and teaches it in a relentlessly teacher-centered way. Whatever else we might say about this scenario, there would at least appear to be a level of consistency, perhaps even honesty, about this teacher’s work.
In this article I want to offer a real as opposed to imagined example of school curriculum that, at least in theory, makes classroom honesty of the kind just discussed difficult to imagine. Although the example that I discuss is concerned with school curriculum, I will go on to suggest that this example has some interesting implications in the realm of social policy, specifically in the area of public health. That is, if we accept that public health policy is a form of curriculum that offers people instruction on how they should live, similar concerns about consistency and honesty might apply.

**What Should/Can We Teach People About Obesity, Physical Activity, and Health?**

Most readers will be aware that obesity is now a global news story. The World Health Organization and a string of national health authorities have described obesity as a global pandemic and among the greatest health challenges facing the planet. This is a conclusion that has been disputed by a number of commentators from both inside and outside the medical research community. In general, the dissenting voices have argued that the health risks of obesity have been exaggerated and that the demonization of fatness by scientists, doctors, politicians, and journalists might not be particularly wise or healthy (for recent examples, see Basham, Gori, & Luik, 2006; Flegal, Graubard, Williamson, & Gail, 2005; Oliver, 2006a).

In this article I will do no more than register the point that the idea that we are in the middle of a global “obesity crisis” has been contested. Interested readers might consult a range of scholarly and popular sources for more detailed elaborations of this critique (Campos, 2004; Flegal et al., 2005; Gaesser, 2002; Gard & Wright, 2005; Oliver, 2006b). In this article I propose to accept, albeit reluctantly, that governments and health authorities around the world are now developing and implementing policies designed to combat the obesity crisis. These policies are taking a variety of forms, from encouraging family doctors to counsel patients more aggressively about their weight (Elliot, 2006), to the development of new weight loss drugs and genetically modified low-calorie foods (Pirani, 2002), and to bans on fast-food advertising on television (Levin, 2004).

However, a mainstay of the “war on obesity” in the past, and no doubt into the future, has been what health promotion professionals call the “healthy lifestyles” message (O’Connor-Fleming, 2001). As the term suggests, healthy lifestyles refers to the idea that individuals need to change the way they live to assist health authorities achieve outcomes they deem to be desirable. This has predominantly entailed educating people about the need to eat what is held to be a balanced diet and be physically active. With only small variations, Western health professionals have been trying to convince people of the virtues of a healthy lifestyle for over a century (Goldstein, 1992).

In more recent years, a range of scholars have considered the way policymakers in Western democracies have gravitated toward the idea of a healthy lifestyle as a way of organizing and communicating healthy policy (for example, see Howell & Ingham, 2001; Lupton, 1995). The idea of a lifestyle, according to Howell and Ingham (2001), emphasizes personal responsibility and the choices that individuals make, a rhetorical move that makes it simpler to blame individuals...
for their own health status. Failure to achieve prescribed levels of health then becomes a matter of moral censure and a case of letting the country down on account of the resources that must now be devoted to making the individual well again. But as Lupton (1995) shows, this emphasis on individual responsibility actually sanctions paternalistic government action and surveillance. It is then a short step to seeing nonconforming individuals as irresponsible and morally lacking.

Have they been successful? There is a view in the health science literature that sees the general populations of Western countries as fundamentally recalcitrant, increasingly addicted to large amounts of bad food, and physically lazy (Lee & Paffenbarger, 1996). However, there is a substantial amount of data that suggests the reverse, that large sections of Western populations have reduced both total caloric intake and the amount of dietary fat in their diets (Rolland-Cachera & Bellisle, 2002) while taking to jogging, gyms, and recreational sports in ever greater numbers (French, Story, & Jeffery, 2001). At the same time, life expectancies have risen in many Western countries, and there are at least some members of the medical research community who are prepared to credit the lifestyle choices of individuals for these improvements (Australian Institute of Health and Welfare, 2004). And yet, obesity levels continue to rise. As they have risen, the call for individuals to live healthier lives has intensified, and healthy lifestyle advertising campaigns are now ubiquitous.

Their ubiquity notwithstanding, the healthy lifestyles message conceals what philosophers will recognize as the Platonic idea of “double truth.” Put simply, the idea of double truth is that there is one truth for privileged insiders—those in the know—and another truth for the mass of society. In the case of the healthy lifestyles message, it goes something like this.

Medical science asks, “How shall we live to enjoy a long and healthy life?” Medical and health scientists set about trying to answer this question through research. Unfortunately, their research produces no clear answers. Although there seems to be patchy support for the idea that a combination of dietary restraint and regular bursts of physical activity provides some health benefits for some people, beyond this there is little else that can be said with any certainty. One after another, reviews of literature lament the inconclusiveness of health research and admit that they are unable to offer precise health guidelines by which people should live (for example, see Berentzen & Sørensen, 2007; Grundy et al., 1999; Jebb & Moore, 1999; Slattery, 1996; Twisk, 2001).

At the same time, concern about what they see as a largely fat, ignorant, and lazy general population means that the medical community feels impelled to say something. As a result, they devise public awareness campaigns to promote healthy lifestyles and lobby governments to support them. They know that a so-called healthy diet is only one small factor in a long list of factors that may affect an individual’s health. They know that every day, physically active people die young from the same diseases as people who are not physically active. They know that the health risks of being overweight are controversial and open to dispute. However, they argue that it is important not to confuse the public. What the public needs are clear, simple rules to follow. In public health promotion, complexity and ambiguity are death.
By the middle of the first decade of the 21st century, a loose consensus between doctors, scientists, and politicians had emerged that schools were an important front line of the war on obesity. A range of school-based initiatives have been suggested and implemented in schools throughout the Western world. This has happened despite wide acceptance that curing or preventing childhood obesity is a complex matter and that very little is known about achieving these goals beyond the level of the individual (Bouchard & Blair, 1999; Muecke, Simons-Morton, Huang, & Parcel, 1992).

Nonetheless, health education is now an accepted and official curriculum area in many countries and to this point it has been one of the primary social policy tools for, at least in theory, delivering the healthy lifestyles message to children. But, as in the field of health promotion in general, deciding to teach children about healthy lifestyles does not answer questions about what and how it will be taught.

Although not strictly empirical, what follows is an analysis of an example of health education curriculum that takes the promotion of healthy lifestyles as its central objective. I offer a critical and selective reading of the Canadian province of Ontario’s Grades 1–8 Health and Physical Education (HPE) curriculum. My purpose here is not to criticize the curriculum writers or to prove that the curriculum could never achieve its stated objectives. As many education scholars have argued, the forms of enactment and effects of specific curriculum documents in schools are unpredictable. What I want to highlight is a specific and, in my view, significant tension in the document, a tension that can be seen in school health education curricula around the world. Having done this, I want to suggest reasons why this tension exists and ways we can read this curriculum as the convergence of diverse cultural forces.

If nothing else, this is an exercise in highlighting the way curricula both create and, in a sense, destroy knowledge. That is, what we might call learning or the organization of knowledge for teaching purposes inevitably involves throwing away knowledge. This idea was neatly summarized by the sociologist Zygmunt Bauman (2004, p. 18), who wrote:

To know is to choose. In the factory of knowledge, the product is separated from waste, and it is the vision of the prospective clients, of their needs or their desires, that decides which is which. The factory of knowledge is incomplete without waste disposal sites. [emphasis in original]

In the following example, showing what knowledge is discarded in an example of curriculum is equally as important as what knowledge is included.

“You Are Free to Make the Correct Choice”

I will approach the current Ontario Grades 1–8 HPE curriculum (Ministry of Education and Training, 1998) by offering commentary on some of the curriculum’s introductory rhetoric and stated outcomes. As with the quote from Bauman, this commentary will be selective, focusing on some elements of the curriculum while ignoring others. My method will be strategically to juxtapose particular statements,
ideas, and pieces of knowledge to emphasize what I see as the document’s contradictions.

Consistent with principles of healthy lifestyles health promotion, the Ontario curriculum adopts an explicit focus on individual choices and behaviors. The document’s opening words are:

Healthy active living involves a combination of physical activity and appropriate lifestyle choices. Students should begin early on to acquire basic knowledge about a wide variety of health-related topics and to develop relevant skills. They need to understand how their actions and decisions affect their health, fitness, and personal well-being, and how to apply their learning to make positive, healthy decisions in all areas of life and personal development. (p. 2)

The mixing of freedom and constraint is immediately apparent. The “choices” children need to make must be “appropriate,” “skills” must be “relevant,” and “decisions” must be “positive” and “healthy.” In my view, the words choices and decisions are noteworthy precisely because they need not be there. For example, road safety education for young children is generally framed as an exercise in behavior modeling. It is not for children to choose or decide how they will behave around road traffic. There are simply rules and behaviors to be learned, repeated, and mastered. In other words, if an identifiable set of “appropriate” and “positive” health behaviors exist, why would we ask children to “choose” them, rather than just instruct children in how they should, or even must, behave?

The Ontario curriculum goes on to describe the role of parents, teachers, and students in achieving the goals of the document. Parents are instructed to participate in their children’s educational lives, read the curriculum document, “promote healthy active living through their own habits and practices,” and “support healthy eating and take responsibility for developing their children’s self-esteem” (p. 3). For their part, teachers are to develop “appropriate instructional strategies” and “bring enthusiasm to the classroom and should model healthy active living in their own lives to encourage students to recognize the value and relevance of what they are learning” (p. 3).

According to the Ontario curriculum, the role of students is as follows:

Students have responsibilities with regard to their own learning, which increase as they advance through elementary and secondary school. Those willing to make the effort required and able to apply themselves soon learn that there is a direct relationship between achievement and hard work. Such students become motivated, self-directed learners. Some students, however, find it more difficult to take responsibility for their learning because of special challenges they face. For these students, the attention, patience, and encouragement of teachers can be extremely important factors for success. Regardless of their circumstances, learning to take responsibility for their own progress and learning is an important part of education for all students. (p. 3)

Many readers will be aware of a long standing critique of the neo-liberal colonization of educational discourse in recent decades (for example, Apple,
2003). A large body of scholarship has questioned the way, as with the passage just quoted, learners have increasingly been positioned as autonomous, self-monitoring subjects, accountable for their own educational success or failure (Hyslop-Margison & Sears, 2006). In the current example, the statement about “special challenges” quoted earlier is the only concession in the entire curriculum document to the possibility that different parents and children might live in circumstances that could constrain their ability to take full responsibility for their own health. Although the influence of neo-liberalism here is obvious, I am less inclined to find fault in this particular passage than might other readers. After all, the idea of children being actively involved and personally committed to the work they do at school is not, in itself, a bad thing. The reason for quoting this passage is to draw attention to the way the document constantly emphasizes concepts such as “self-direction” and “responsibility” as cornerstones of learning. That is, the curriculum seems at pains to connect self-direction with educational success. Although education scholars have objected to neo-liberalism’s moral agenda of personal responsibility and accountability, my interest here is pedagogical: Is it really the case that self-directed learners do best and, if so, how does the curriculum go about facilitating and rewarding this disposition among students?

The Ontario curriculum is divided into three content strands. The curriculum lists and explains these as follows:

The curriculum’s major areas of knowledge and skills are organized around three strands:

• **Healthy living** includes healthy eating, growth and development, personal safety and injury prevention, and substance use and abuse.

• **Fundamental movement skills** include locomotion/traveling, manipulation, and stability.

• **Active participation** includes physical activity, physical fitness, living skills, and safety.

These strands combine the living skills (e.g., personal, interpersonal, communication, conflict resolution, goal-setting, organizational, time-management, problem-solving, and decision making skills) that all students require. (p. 3)

Once again, legitimate questions could be raised about the list of “living skills” that “all students require.” However, in keeping with the focus of this article, the explicit link between knowledge, skills, and student choice (“goal setting,” “problem-solving,” “decision making”) is what interests me here. This connection is articulated more clearly as we move into the sections of the document that provide explicit content and learning outcomes for the Healthy Living strand. Here we read that:

The healthy living strand will provide students with the knowledge and skills they need to develop, maintain, and enjoy healthy lifestyles, as well as to solve problems, make decisions, and set goals that are directly related to personal health and well-being. (p. 10)
At the risk of belaboring the point, the pedagogical process that is being advocated here is one in which sound knowledge and skills lead to sound decisions, which in turn, lead to healthy behavior and a healthier life. In the words of the document:

Students require knowledge to make healthy eating choices. Using this knowledge, they will examine their own food choices and eating patterns, and then make wise decisions and set appropriate goals. (p. 10)

As in most modern institutionally educational contexts, the difficult question now becomes what knowledge children need to learn and how this will be assessed. The overall learning objectives (called “Specific Expectations”) of the curriculum for grade-1 children (age six or seven) include that they will “identify healthy eating habits” (p. 10). Among other things, grade-2 children (age seven or eight) are expected to “identify a balanced diet and apply decision-making skills to create menus for healthy meals,” and grade-4 students (age nine or ten) must “analyze, over a period of time, their own food selections, including food purchases (e.g., ‘everyday food’ versus ‘sometimes food’) and determine whether they are healthy choices” (p. 10).

It is interesting to note that, apart from some general definitions at the end of the document (for example, balanced diet is defined as “healthy eating based on the four food groups” [p. 39]), few of the central concepts used in these learning objectives are clarified. It is difficult to avoid the conclusion that the curriculum writers have assumed the concept of “healthy” or “balanced” eating habits to be self-evident or sufficiently well known to not require explanation. This is perhaps not so surprising because clear and widely agreed on definitions for these concepts are difficult to find.

For example, Marion Nestle’s Food Politics (2002) is a detailed study of the behind-the-scenes political machinations involved in producing what, in North America, is widely known as the “healthy diet pyramid.” The healthy diet pyramid is a pictorial representation of what some nutritionists claim is a healthy diet. Although it has been amended many times, it generally recommends that people eat—moving from most often to least often—complex carbohydrates (for example, bread, cereals, potatoes), fruits and vegetables, dairy products (for example, milk, cheese, and yogurt), meats (red, white, and alternatives), and finally, a category containing sugary and oily foods (such as sweets, soft drinks, and other junk foods). Nestle shows how the economic and political power of “big food” lobby groups and a wide range of government and industry interests shape the recommendations embodied in the healthy diet pyramid. For example, she points to what she sees as the inordinate influence of the dairy industry in defending and promoting their products. Although not universal, it is certainly a mainstream view among nutritionists that scientific research shows that Western populations should cut down on dairy food consumption and that the dairy recommendations of the healthy diet pyramid are too high (Barba & Russo, 2006; Risch, 2006).

The same can be said about complex carbohydrates, the food that most versions of the healthy diet pyramid encourage us to eat most often. In fact, writers such as Rolland-Cachera and Bellisle (2002) have argued that the primary nutritional cause of rising obesity levels is the increasing amount of complex carbohydrates that Western populations consume. This is not an extreme or radical view. For example, McMichael (2002) has argued that the case against carbohydrates is
obvious. His view is that humans evolved as meat and root-vegetable eating creatures and that our bodies are not well suited to processing large amounts of bread, pasta, and other cereals. Somewhat more radical nutritional researchers, such as Dale Atrens (2000), have argued, in essence, that nutritional science has nothing useful at all to teach us. In fact, Atrens’s argument is that nutritional science is less marked by the production of robust scientific truths and more by the generation of a stream of quickly forgotten nutritional fads (folic acid, antioxidants, etc.) that enjoy poor empirical support.

I offer no opinion about what might be the correct scientific definition of a healthy diet and, in fact, doubt that such a definition exists. However, as quoted earlier, the Ontario curriculum asks young children to not only monitor their own food intake, but to analyze and evaluate it. It is important not to forget that these educational activities will happen in the context of widespread talk of an obesity crisis and the curriculum’s stated objectives that children should make “appropriate” and “healthy” choices.

In my view, it is clear that there are, in fact, no choices for children to make in the context of this curriculum. Despite the rhetoric of gathering knowledge and then making informed decisions based on this knowledge, children are expected to make “healthy” choices that reflect traditional “healthy lifestyle” messages. After all, primary school teachers will rarely have specialist expertise in scientific nutrition, and there is some evidence to suggest that teachers, if they teach nutrition at all, will do so using standard, mass-produced healthy lifestyles teaching materials such as the healthy diet pyramid (Leahy & Harrison, 2006).

In the abstract, I can imagine a child being presented with the diversity of nutritional opinion (knowledge) that exists (discussed earlier) and deciding that no clear course of action suggests itself. This child might decide that, all things considered, it is better to see food as something to be enjoyed rather than monitored, analyzed, and judged. Therefore, they might choose to either abstain from judgment or even come to a different conclusion than those offered by simplistic healthy lifestyle messages. However, my reading of the Ontario curriculum is that this imaginary child’s decisions and choices would be seen as incorrect.

What Do We Really Know About Physical Activity?

If anything, when it comes to physical activity, the Ontario curriculum seems to move away from its informed “choice” and “decision making” rhetoric. The preambles to the document’s third content strand, Active Participation, opens with:

Daily vigorous physical activity must become part of each child’s routine and way of life. The health and physical education program, which includes vigorous physical activity for all learners throughout the school year, will help children to become fit, independent learners; to develop interpersonal skills by interacting with others; and to relate fitness activities to healthy, productive lives. (p. 30)

The curriculum’s Specific Expectation for grade 2 (age seven or eight) includes “identify the reasons for participating in regular physical activity” and “display readiness to participate in the instructional program” (p. 32), and grade-3 children (age eight or nine) are expected to “describe the health benefits of
participating in regular physical activity” and “adopt an action plan based on an individual or group goal related to physical activity” (p. 33).

In a straightforward sense, we might wonder about the wisdom of expecting young children to enthusiastically take up “action plans” for their own physical fitness and, presumably, to monitor their own progress. In my view, it is extremely difficult to imagine grade-3 teachers across Ontario insisting that all their students formulate fitness plans that they then enact and monitor in any meaningful way. To me, what is most striking is that a group of curriculum writers could imagine such a task being practical or ethical on a mass scale. Quite apart from whether readers share my concerns about the way these tasks seem determined to turn physical activity into work rather than play, the lack of specialist expertise in schools creates the possibility that students will choose or be made to do physical activity that is overly strenuous, a situation that has obvious legal risks.

But returning to the specific focus of this article, there must also be questions about the knowledge base students will be asked to work from. It is now widely acknowledged that demonstrating the health benefits of physical activity for children is extremely difficult. For example, the exercise scientists Boreham and Riddoch (2003, p. 17) have written, “Although we feel instinctively that physical activity ought to be beneficial to the health of children, there is surprisingly little empirical evidence to support this notion.” In a comprehensive review of studies that measured the link between childhood physical activity and long-term health, Twisk (2001) found no evidence to support such a link. In fact, he concluded by arguing against making recommendations about why or how much physical activity children should do because, first, the promise of long-term health benefits does not appear to motivate children to be more physically active and, second, because there is no scientific case for doing so. It should also be noted that demonstrating anything other than very short-term health benefits from vigorous physical activity has proved very difficult in adults as well as children. In short, this remains a controversial area of research marked by an extraordinarily wide range of views.

I am struck by the difficulties an imaginary grade-3 child might have with the expectations of the Ontario HPE curriculum, such as describing “the health benefits of participating in regular physical activity,” if they were invited to choose for themselves from the various competing points of view that exist. This is certainly a question I would have a great deal of difficulty with despite years of studying the subject. However, as the Ontario curriculum is written, only one view, the healthy lifestyles view, appears to constitute an “appropriate” choice.

It might be argued here that elementary school curricula need to start somewhere, and that young children need to be introduced to simple concepts that can be problematized and extended as students get older. Regardless of whether one sees this as a reasonable assumption to make about the education of young children, my view is that this argument does not accurately describe the context I am discussing. The idea that physical activity confers general health benefits on all people and that physical activity is an essential part of a healthy lifestyle is not, in my experience, one that is ever problematized or extended in school education. Rather, it is a vague idea that seems to operate in Western culture as a kind of myth. I use the word myth here, like Booth (1998), to describe an idea that (regardless of its claims to empirical truth) is widely held by people with no particular expertise or specific reason to believe the idea other than its sheer ubiquity. Indeed,
judging by the resistance of my own university students to views that do problematize physical activity’s health benefits, we are dealing here with a cherished cultural belief rather than an object for dry scientific conjecture.

When Curriculum and Social Policy Collide

Although the Ontario HPE curriculum generally lacks precise conceptual definitions and prescriptive instructional direction, its relationship with the wider anxiety about an obesity crisis is clear. A series of media reports and curriculum support documents also appear to confirm the Ontario Ministry of Education and Training’s (the document’s official author) desire to at least appear to be taking the problem of childhood obesity seriously (for example, Livingston, 2005; Morse, 2005). Because of this, the curriculum seems also to be informed by popular (although highly debatable) claims that today’s children are less physically active than previous generations and generally addicted to high-fat food. In short, the curriculum appears to be designed to address two specific and related social policy problems: childhood obesity and the reduction of health care costs.

This preoccupation with social policy agendas is the tension that I have tried to draw attention to in this article. Put simply, my argument here is that if school education, in this case health education, is seen as an arm of social policy, then it is not surprising that official school curriculum will be highly prescriptive and, in effect, “dumbed down.” As I argued earlier, the healthy lifestyles agenda is predicated on a simplification of scientific knowledge. Healthy lifestyles as a form of public health social policy is not at all interested in having people engage carefully and thoughtfully with public health issues. It simply wants to change people’s behavior.

With this in mind, what are we to make of the Ontario curriculum’s claim that self-directed learners do best? My sense is that it is the self-directed learner that the healthy lifestyles agenda seeks to eliminate. Instead, the student most likely to do well in this context would seem to be one who can rote learn a set of rules and repeat them on demand. What is important here is not a student who can sift through different knowledge claims and arrive at a reasoned choice or decision, but rather a student who can perform a predetermined set of behaviors. So, when we read:

Students require knowledge to make healthy eating choices. Using this knowledge, they will examine their own food choices and eating patterns, and then make wise decisions and set appropriate goals. (p. 10)

it is apparent that “wise decisions” and “appropriate goals” refer to things that children must do, as opposed to things children must feel, think about, or believe.

In this context it is worth remembering that, alongside its obvious healthy lifestyles agenda, the curriculum also includes objectives that relate to students’ behavior, such as the expectation that students will “display readiness to participate in the instructional program” (p. 31). In the Ontario HPE curriculum, the performance of classroom compliance by students is an assessable task. Similar to food and physical activity, compliant classroom behavior is being firmly located within the sphere of a child’s individual responsibility.
As we have seen, the curriculum does not only set down behaviors it constructs as “wise” and “appropriate” for children. Parents and teachers also have a role to play, and the curriculum states that both groups should exhibit behaviors that model healthy lifestyles to children. As with students, it does not invite parents and teachers to think about the issue of childhood obesity or the different knowledge claims that might influence one’s beliefs or behavior. The curriculum simply assumes the right to both define and expect certain forms of behavior from parents and teachers.

Although not the focus of this article, this apparently casual foray into the lives of parents and teachers is, in my view, both unusually presumptuous and a clue to understanding the forces that are shaping school health education curricula around the Western world. To begin with, within what has come to be called the reconceptualist approach to curriculum (Pinar, Reynolds, Slattery, & Taubman, 1995; Pinar, 2006), it is now commonplace for scholars to blur the boundary between official school curriculum and the pedagogical work done by other social institutions such as the media, science, and government. One way this blurring of boundaries functions is to see general social and cultural forces, processes, and artifacts as forms of curriculum, forms that might be more significant and powerful modes of education than anything that happens in schools. However, a second way is to consider the extent to which school curricula are indistinguishable from other forms of curriculum. That is, although we might imagine that schools are places in which children receive instruction about things that are particular to schools, in some contexts it might be more accurate to see schools simply as part of a wider integrated ideological apparatus.

It is important to stress that I am not indulging in neo-Marxist conspiracy theories here. I am pointing to the way particular social problems, such as obesity, can so capture the attention of policy makers and the general public that a wide range of institutional forces are marshalled to combat this problem. For over a decade, members of the medical and scientific communities have been calling for a war on obesity and arguing that schools and other institutions be conscripted into this war. That medical science should feel able to offer opinions about what children are taught in schools is perhaps testimony to the relative power of different knowledge traditions. It is certainly difficult to imagine medical science taking much notice if groups of teachers began making recommendations about the conduct of medical research or practice.

This point could also be extended to university departments that prepare health and physical education teachers. There are clear signs that the academic physical education community, some of whom contribute to the kinds of curriculum documents discussed in this article, have wholeheartedly embraced the obesity crisis agenda even though they seem not to have critically engaged with the knowledge claims underpinning the crisis rhetoric they espouse (for a striking example, see Himberg, 2005. For a response to Himberg, see Gard, 2006). This is perhaps not surprising given that historians of physical education locate the very origins of the profession in reaction to 19th-century concerns about the health of Western populations (Kirk, 1998; Smith, 1974). There is, in other words, a long history of physical educators taking their lead from outside the profession.

In any case, as schools have been folded into the war on obesity, they have been presented with a particular kind of pedagogical task. This task involves being
nothing more than a conduit for already formed healthy lifestyle messages. The originators of these messages within government and the fields of medicine and public health neither want nor expect teachers to shape or change these messages on their imagined journey into the minds of children. Teachers simply need to deliver the messages, and children need to act on them.

And yet there are problems. On the one hand, the field of health education (as opposed to the broader field of health promotion) has long realized that public health objectives are rarely achieved simply by telling people how to live. This is why the idea of informed decision making became a mainstay of health education practice, an idea that wants individuals to take “ownership” of particular health issues and to transform their behavior because they want to.

On the other hand, through the course of the 20th century, educational discourse increasingly turned against so-called teacher-centered or “transmission” approaches to teaching. So just as modern liberal democracies have become sensitive to the whiff of authoritarian public policy (regardless of whether this sensitivity is particularly vigilant), so too is educational discourse imbued with liberal notions of student choice and self-directed learning. My argument here is that it is because of the rhetorical clash between the imperatives of health promotion on the one hand—people must change their behavior in particular ways—and liberal educational discourse on the other—people should make up their own minds based on available knowledge—that the Ontario HPE curriculum appears to mix these two rhetorical tendencies. As a number of theorists have argued, curricula are the product of negotiation, contestation, and compromise. They are, among other things, artifacts of a process rather than distillations of a single, internally consistent and coherent educational vision. However, in this specific example, the colonization of health education curricula by healthy lifestyles rhetoric is not simply the artifact of a process, but also represents the victory of one pedagogical vision over others.

The things that children are made to do in schools have always been, at least in part, the product of broad ideological struggles as well as a response to society’s perceived ills. However, in the case of the war against obesity, moral censure and individual responsibility are now fundamental discursive ingredients in debates about obesity social policy and, by extension, the shape of school health education curricula around the world. For this reason, it remains to be seen how durable the rhetoric of “choice” and “decision making” will be in health education. Might healthy lifestyles education be headed in the direction of road safety education in which the rhetoric of choice is not even attempted? We should remember that a range of commentators about the “obesity crisis” have already argued that obesity is a moral issue and that getting fat is a personal failing and a burden on the rest of society (for example, Critser, 2003).

My contention in this article is that the profession of physical education simply has neither the intellectual tradition nor the tools to confront the “obesity crisis” with anything other than intellectual passivity. The tradition of deferring to governments and scientists means that we can do little more than ask the teachers that we train to be as passive as we ourselves have been. We ask teachers or children to be critical consumers of health knowledge because we do not have the skills ourselves. My suggestion is that we need to begin to develop traditions and skills that might lead to pedagogical responses other than telling children (in a
highly teacher-centered way) that they are (in a student-centered way) responsible for their own health.

In this context, the best we could say about the Ontario curriculum is that it neither expects from children nor offers them any form of intellectual resistance to the rhetoric of moral censure and individual responsibility. Its mantra of “positive,” “appropriate,” and “healthy” choices is actually a call for obedience. But to call for and reward obedience, it must gloss over the uncertainty that exists within the fields of knowledge it claims to represent. In fact, when curriculum becomes an explicit and direct arm of social policy, it is difficult to see how the situation could ever be otherwise. This is particularly the case when social policy and curriculum documents seek not to change the circumstances in which people exercise personal choice but rather the choices themselves, thereby sowing the seeds of resistance.

References

Producing Little Decision Makers


