

VIRTUE WITHOUT EXCELLENCE, EXCELLENCE
WITHOUT HEALTH

In this paper I respond to Edward Harcourt's suggestion that human excellences are structured in a way that allows us to see the multiplicity of life forms that can be instantiated by different groups of excellences. I accept this layered (as he calls it) model, but suggest that Harcourt's proposal is not pluralistic enough, and offer three critical points. First, true pluralism would need to take a life-cycle view, thus taking into account plurality within, as well as between, lives. Second, Harcourt's pluralism still posits physical health as a requirement for excellence, whereas I claim that the challenges of illness give more, not less, opportunity for excellence. Third, I make a more general claim that in certain salient cases (illness being one of them) it is precisely the absence of excellence that can facilitate virtue.

I

Introduction. In his thoughtful paper [Edward Harcourt \(2016\)](#) draws a possible map, onto which he superimposes three sets of concepts: virtue and vice, health and illness, excellences and defects. On his analysis, human excellences can be seen as either (a) 'the characteristics we need in order to *live* as humans characteristically do' or (b) 'the characteristics we need in order to *excel* (or *flourish*) in *living* as humans characteristically do' (p. 219). As Harcourt notes, (b) is an idealization of (a). One problem is that (b), the idealizing sense of 'characteristically', either gives unreliable answers to the question 'Which features are excellences?' or it begs the very question. The aim of his paper is to make (b) 'a more comfortable place to be', by suggesting that human excellences are structured in a way that allows us to see the multiplicity of life forms that can be instantiated by different groups of excellences (p. 228). As Harcourt says, 'if "flourishing" for human beings is a layered notion, the fact that some humans may not be "flourishing" in some maximally

demanding way does not imply they are not “flourishing” at all’. This paves the way for a pluralistic notion of a human life form, in which different layers ‘determine different classes of human excellences’ (Harcourt 2016, p. 228).

I agree with this analysis, and with Harcourt’s proposal; indeed, a theme of virtue ethics, historically, is that there is a rich plurality of modes of a flourishing life. This point is made explicitly, for instance, by Aristotle and Confucius, and indirectly, by the fact of the plurality of conceptions of the good life provided and exemplified by different traditions (see [Angle and Slote 2013](#); [Nagel 1980](#); [Ackrill 1980](#)). However, I think that Harcourt’s proposal is not pluralistic enough. In what follows, I offer two ways of expanding his proposed pluralism. First, using the notion of life cycle, I suggest that there is plurality within, as well as between, life forms. Second, I suggest that Harcourt overlooks the important possibility of flourishing despite diminished excellences, and as a result unnecessarily narrows the ‘space of flourishing’.

Where I disagree with Harcourt is on another point. Harcourt (2016, p. 231) writes, ‘[S]omewhere in the course of our descent, the life-form concept in question will surely be physical health: people who are extremely ill can do almost nothing, so presumably at least the absence of that is something we also need, and its presence . . . [is] a defect’. It seems that Harcourt takes physical health to be a bedrock on the basis of which human excellence can proceed to develop, either partially (as in his example of people who can keep promises, but use these to participate in a slave trade, and are therefore not maximally excellent) or fully (as we would see in someone with fully developed virtues).

This, I think, is wrong for at least two reasons: first, illness and other forms of capacity loss like ageing are constitutive of the human condition. Excluding them from the realm of possible excellence leads to a paradox: an ill person is doing what is characteristic to the human species (being unwell or incapacitated at certain points of their life) and yet is—for this very reason—labelled as uncharacteristic. This view restricts plurality and stems from the implicit acceptance, rife throughout contemporary philosophy, that the life under consideration is the life of a relatively young, healthy, able-bodied person, and that diminishment in any of these features will necessarily lead to impoverished living. This strikes me as a misrepresentation of human life, and also as a tacit stipulation that

unnecessarily restricts plurality in Harcourt's model. I expand on this below, but for now emphasize that this is not just the claim that illness is statistically common, but a deeper claim about vulnerability and affliction being essential to human nature as we currently know it.

The second reason is this: nearly all human beings—especially historically—are, were, or will be ill: so it is odd to effectively confine the scope of flourishing to such a select group, especially given Harcourt's stated commitment to varied modes of living characteristically. Seeing this requires a life-cycle view of human life, as I propose below. The absence of the life-cycle view and tacit focus on relatively young, healthy persons as the ones most able to engage in different types of 'doing' stem from pathophobic prejudices that seem to run through much philosophical reflection on the good life (see Carel 2007, 2016). Such prejudices restrict our conception of the good life, as well as dismissing the rich activities that ill people, and even very ill people, can engage in. It is not true that 'people who are extremely ill can do almost nothing', as Harcourt claims. On the contrary, from the point of view of virtue ethics one could argue that facing infirmity and adversity is a challenge requiring moral and philosophical work and thus has high moral and edificatory value, even if it is terrible in other ways.

In what follows I present my objection to this view of physical health as the bedrock of flourishing, and also place a further question mark by Harcourt's more general assumption that certain excellences are needed in order to facilitate maximal excellence and virtue. I suggest that his pluralistic model is not pluralistic enough, and that he does not consider cases where it is precisely the absence of excellence that facilitates virtue (the absence of physical health being an exemplar of such absence).

These two suggestions stem from a more general observation about much of contemporary philosophy, and in particular moral philosophy: it often lacks consideration of human life forms as evolving both phylogenetically (culturally and socially, in groups) and ontogenetically (in the individual). To remedy that, I draw on the biological idea of the life cycle in order to suggest that we need to look at human life forms as constantly evolving, and as making different moral and educative demands on the person at different times. I suggest that we need to take this life-cycle point of view

when assessing whether a particular life form corresponds to a certain way of being or to some exemplary way of being.

II

The Life-Cycle View. This point of view reveals that there is, essentially to our species as it currently exists, a period in which we are helpless and depend on others' care (before and at birth, and during infancy), as well as a period in which our physical and mental capacities diminish and we become dependent once again. However, the assumption that the period in between is one of health, independence and reasonable immunity to calamity is, in fact, false. Within adulthood we are still vulnerable to accident, illness, trauma, and other forms of adversity. As Alasdair MacIntyre (1999) argues, we are continuously susceptible to affliction, and are hence deeply dependent on others. Our bodies fail us in a myriad of ways, ranging from the mild (being a bad dancer) to the catastrophic (suffering a stroke) (cf. Carel 2016). Moreover, these periods of dependence and affliction are not ones in which the presence of excellence and indeed of a life form, is not required. On the contrary. For every stage of development there will be some corresponding excellences, and for some a variety of virtues, and these will likely match developmental concepts such as thriving and developing appropriately.

This point is reflected in some philosophical writings on ageing and virtue. Cicero and Montaigne, for instance, argue that different virtues and types of project are proper to different stages of life—courageous military service for the young, reflective reverie for the old. Montaigne contrasts the 'knowledge and experience' of the mature person with the 'vitality, quickness, [and] firmness' characteristic of the young (Montaigne 1993, p. 122). Cicero comments that 'old age has its own appropriate weapons' (1971, p. 218), and suggests ways of flourishing in old age. The ascribed author of *Ecclesiastes*, King Solomon, states that 'To every thing there is a season, and a time to every purpose under the heaven: A time to be born, and a time to die; a time to plant, and a time to pluck up that which is planted' (*Ecclesiastes* 3:1–2). Wisdom, for them, partly consists in grasping this life-cycle view of human life and knowing what aspirations and virtues are appropriate to each

stage. Such reflection, and such a view, seem largely absent from much contemporary discussion about the good life.

I suggest that in order to have a truly pluralistic model we must not only view different life forms as legitimate, but also different stages of a single life form. Harcourt suggest a synchronic view of pluralism: there are different ways to live characteristic to our species, he says. I agree with this, but suggest we also need a *life-cycle pluralism* that captures the diversity and plurality of the human life form at its different stages.

Let us look diachronically at a life. What we find excellent—indeed endearing—in an infant: a toothless grin, babbling meaningless sounds, or, later on, making grammatical errors ('My do it!'), we would find defective and inappropriate in an older child or adult. We are discerning in this respect, and within the confines of cultural expectations we make the relevant allowances for young children, adolescents, and, markedly less successfully, for old age and its associated frailties. Taking a first stab at social communication, striving towards language, and so on, are excellent for that life stage but not later ones.

Thus, I suggest, Harcourt's model needs to be expanded. The model requires the layering he lists: moral and other virtues, underpinned by other excellences such as promise keeping, which are, in turn, scaffolded upon more basic excellences, such as cognitive function, capacity for attachment, ability to play, and so on. But it also needs to include the life-cycle layering which would considerably complicate the picture, because it is this layering—one thing happening *after* another—that enables mature excellences and virtues to emerge. Take, for example, crawling: crawling develops laterality, and is thus a prerequisite for handwriting, reading, and other activities 'that require the awareness of sidedness' (Kranowitz and Newman 2010, p. 15). Babies who 'crawl briefly or do not crawl at all' often have problems with such activities later on (*ibid.*). What is excellent for an eight-month-old baby (repetitive babbling) is not remotely excellent for an eight-year-old, but it is only in virtue of the babbling that speech is possible. Hence the excellences are interconnected in a developmental sense, and seeing that requires a life-cycle view.

Aristotle's idea of *telos*—which can be taken to support this developmental perspective—does not just see *telos* as the purpose or end to which creatures naturally aspire, but also the *processes* (moral,

cognitive, and other) they pass through to get there. If we watch a young child practise a new skill, we can see that the goal is not just the end point of the practice, it also saturates the practice itself, lending it structure and direction. Moreover, the goal makes the child strive towards a *particular* way of performing the skill. She doesn't simply want to eat, she wants to eat in a specific way: using a fork like her big sister. The different stages of such processes are not meaningful merely in virtue of the end product—upright walking, or writing—but are infused with such striving in their own right. It would be quicker to use her fingers, but she wants to eat in a way that exemplifies some excellence for her.

Thus we find Alasdair MacIntyre's emphasis, in *After Virtue* (1985), on the multiple embedding of a set of virtues within a *telos* within a conception of the good within a society shaped by a tradition to be helpful here, too: it supports the 'layering' view Harcourt promotes. One role of a moral and cultural tradition is to lay out the different ways that a life could and should go. Thus the *telos* is in part moulded by tradition, social practices, and particular conceptions of the good. And this opens the door to great variation in both how *telos* is conceived by a particular group, and in how it is practised towards by individuals.

To conclude the first point, different excellences are appropriate to each life stage and, moreover, each excellence emerges from and is scaffolded upon earlier excellences, and is thus dependent upon, and intimately connected with them. Therefore, a full account of human excellences requires a developmental view, that is, a life-cycle view, of the human life form.

III

Physical Health is not the Bedrock of Excellences. Suggesting that physical health is a bottom rung on the excellences-layering ladder, a *sine qua non* of living in accordance with one's species potential, as Harcourt does (2016, p. 231), neglects the fact that some of our most exuberant opportunities to exhibit excellence (of character, moral and otherwise) emerge from the absence of physical health, whether by facing illness or by caring for an ill person. Falling ill is an unwanted event that has global and deep impact on every aspect of life (Carel 2013a). Serious illness (I will use 'illness' as shorthand

for serious illness hereafter) often causes incapacitation, anguish, social isolation, and sometimes loss of earnings, pain, and loss of autonomy. It disrupts one's way of being, causing disability, pain, anxiety, a narrowing of one's physical and spatial horizons, and disrupted identity (Carel 2013a; Toombs 1987, 1988, 1990). It is a deeply unsettling experience of adversity, which often leads to crisis, loss of faith in one's body (Carel 2013b), and 'biographical disruption' (Bury 1982). In short, it is one of the biggest challenges humans face, whether in falling ill themselves or by witnessing a loved one fall ill.

How one responds to this challenge is revealing. One can respond with excellence, and even with virtue: one can face their illness courageously, cultivate equanimity in the face of fleshly suffering and imminent death, and continue to be cheerful and trusting despite fatigue and incapacitation. One can respond with dignity and authenticity to the indignities inflicted by illness. Human excellences surely must also include excellence displayed in one's response to adversity, and illness is a central and most exacting adversity. If it is chronic, it may continue to challenge the lived horizons of the ill person for decades; if it is acute, it often throws the ill person's entire life, and the lives of those around her, into chaos and uncertainty. Illness is also morally demanding: it requires turning our attention to diminishing bodily capacities and death. It reveals our bodily and mental vulnerability, it may disillusion us about certain relationships, and is often a violent uprooting of our tacit beliefs and expectations.

Illness is a deep challenge, and as such can teach humility, forgiveness (often to ourselves), patience, acceptance and fortitude, amongst other virtues. Courageous acceptance, resilience and reflective coping may enable the ill person to bear their illness well. However, as Ian James Kidd (2012) argues, that does not mean we should seek out illness; it is a misfortune. But although illness is unwanted and unwelcome, one's reaction to such adversity may cultivate excellence by eliciting particular responses to it (Carel 2014b). A template for such a response is found in Epictetus (1877): 'What is it to bear a fever well? Not to blame God or man; not to be afflicted at that which happens, to expect death well and nobly, to do what must be done' (*Discourses*, bk. III, ch. X, 'In what manner we ought to bear sickness'). This exemplary response to illness outlined by Epictetus is particularly important within the Stoic world view,

which sees our behaviour and attitudes as the only elements of life we have control over, since all external things, including life events, are beyond our control (Sellars 2006; Epictetus, *Encheiridion*, §1). But it has broader significance across many traditions that see illness as having an edifying potential (which is not to say that any of these traditions advocate deliberately falling ill).

Kidd examines the edifying potential of illness and its ability to promote the cultivation of virtue. He suggests that illness has the ‘capacity to enable a person to cultivate and express their virtues, either as a practicable response or within the more ambitious ethical project of pursuing “the good life”’ (Kidd 2012, p. 503). This does not make illness desirable, nor impose ‘intolerable burdens’ on the ill person, called upon to be edified (ibid., p. 506). Rather, I suggest that illness is an ‘invitation to philosophize’ or a gateway to reflection that is of its very nature philosophical (Carel 2014b). For example, reflecting on death as timely or untimely, on suffering and its possible consequences, and the meaning of illness as an expression of our vulnerable, limited existence, are some common reflections elicited by illness that are also time-honoured philosophical themes (Carel 2014b; cf. Hadot 1995; MacIntyre 1999; Nagel 1993).

The ideas of edification through suffering and of a plurality of modes of flourishing is deeply rooted in many of the world’s cultures (religious or not), and continues to inform the reflections and lives of many ill people. Flourishing, or excellence, is not a possibility but a lived reality for many ill people, hence one for philosophers to take seriously. We should therefore look more closely at the kinds of excellence that may emerge from, or be cultivated by, illness, and study the means by which illness may elicit excellence. Certain human capacities can only be exercised in situations of suffering, affliction and distress, so the human ‘space of flourishing’ is not exhausted by the ‘space of health’.

This view coheres with empirical findings in health economics, psychology and qualitative health research. These describe the relationship between illness and flourishing as complex and non-linear (Angner et al. 2009; Brennan 2012; Brickman et al. 1978). Of course, researchers and respondents may mean quite different things when they refer to happiness, flourishing or well-being, and of course these are distinct from excellence, but in so far as we can treat these terms as a cluster of related concepts we can use the existing empirical evidence to make the following observations. First, the

evidence largely coheres. Studies in the different disciplines, using a range of methods, and examining diverse patient groups, largely point to a smaller than expected but consistent reduction in levels of well-being occurring in illness, compared with healthy controls. Second, the evidence points to a process of adaptation that is relatively well understood, which can explain the findings. Third, the adaptation to illness or disability is not complete, and reflects a realistic understanding of one's condition rather than self-deception or denial. What I suggest the empirical evidence points to is that health is not a requirement for excellence or flourishing, and that often its absence can be the source of new forms of excellence, much to the surprise of those involved.

As Kidd (2012) points out, certain of a person's qualities and capacities might only be drawn out in a situation of suffering, what psychologists have termed 'post-traumatic growth' (Haidt 2006). In order to realize that one is in fact resilient, courageous or patient, one needs to be faced with circumstances that require such qualities, and illness is one such circumstance, perhaps the most common one, shared by almost all humans at some point in their life.

Qualitative health research confirms the notion of post-traumatic growth. Many studies report that ill people have a more focused and developed sense of self, a stronger sense of their priorities, more authentic relationships, and a better ability to resist petty upsets (Spiegel 1998). The sense of salience, appreciation of time, cherishing and sharpening perceptions of beauty and joy, more authentic relationships, better self-knowledge, and heightened sense of purpose have all been noted in qualitative studies of illness and in pathographies (Frank 1991; Carel 2013a). This does not mitigate the negative effects of illness, but shows that illness is a more varied experience that may contain surprising positive elements (Haidt 2006; Gilbert 2006). One such element is the possibility of edification through the cultivation of virtue in response to illness.

Some qualitative research themes note participants' view of illness as affording personal growth through awareness; as transformational change; a tool of self-discovery; honouring the self; creating opportunities; and celebrating life (Lindsey 1996; Thorne et al. 2002). Interestingly, these themes mirror some ancient writing on illness, for example, Boethius' view of illness as a tool of 'self-discovery' as well as the Cynics' view of hardship in general as essential to human moral growth (Kidd 2012, p. 507). Spiegel provides a

neat summation of these themes in his study of women with breast cancer: ‘They trivialized the trivial in their life, turned down unwanted obligations, and concentrated on what mattered, given their dwindling resources’ (Spiegel 1998, p. 67).

This robust set of findings relates to an anomaly that has troubled health economists and psychologists for some time, known as ‘the disability paradox’: ‘Why do many people with serious and persistent disabilities report that they experience a good or excellent quality of life when to most external observers these people seem to live an undesirable daily existence?’ (Albrecht and Devlieger 1999, p. 977). ‘Across a wide range of health conditions, patients typically report greater happiness and quality of life than do healthy people [asked to imagine themselves] under similar circumstances’ (Ubel et al. 2005, p. S57). Again, adaptation is offered as the most likely mechanism that can explain the paradox, as it explains why what seems like an intolerable affliction from the outside (stereotypical deficit-focused view of the condition) gives rise to flourishing and excellence from the inside (the ill person who has adapted to their condition). Such schematic, stereotypical understanding of ill health may lead philosophers, many of whom view it from the outside, to posit health as a necessary condition for excellence. But it is the insiders’ view that can reveal the complexities, adaptation, and creative responses to the absence of health, and also the excellences and virtues that may be cultivated by this absence (Carel 2014a).

The case of illness generalizes to other absences of excellence. Perhaps radically reduced opportunities in one’s early life, trauma, imprisonment or extreme poverty are further examples of cases where the absence of essential components of a human life form does not preclude the possibility of excellence (although we should vigorously oppose such conditions). A poignant example can be found in Primo Levi’s account of his time in the Nazi concentration camp Auschwitz. Levi recounts how Charles, a survivor of the camp who is awaiting rescue after the Germans’ hasty retreat, cleans, comforts and supports a dying fellow survivor of the Nazi atrocities, Lakmaker, despite the complete dearth of resources, his own illness, and the risk of infection:

[Charles] lifted Lakmaker from the ground with the tenderness of a mother, cleaned him as best as possible with straw taken from the mattress and lifted him into the remade bed in the only position in which the unfortunate fellow could lie. He scraped the floor with a scrap of tin-plate, diluted a little chloramine and finally spread disinfectant over

everything, including himself. I judged his self-sacrifice by the tiredness which I would have had to overcome in myself to do what he had done. (Levi 1947, pp. 199–200)

MacIntyre (1999, ch. 1) is sensitive to the vicissitudes of life, and to the near inevitable presence of ageing and illness. In response to these, he characterizes human life as deeply susceptible to events beyond our control. He argues that ethical and political philosophies have tended to disregard the fact that the lives of human beings are generally marked by affliction, vulnerability and dependence, with the consequence that our conceptions of the good life and of a just society are therefore designed with an idealized image of the moral agent—independent, rational and autonomous—which obtains only temporarily and incompletely, and only for some. MacIntyre therefore argues that ethical and political thought ought to be reformed to reflect the fact that most persons are, in his phrase, ‘dependent rational animals’.

Ageing and illness are not just practical problems we deal with as individuals or as a society. They are also a challenge towards which many of our moral resources are directed. Much of Stoic and Epicurean writing is aimed directly, and often solely, at the question of coping. Their response, a form of reflective coping, is a prime form of cultivation of moral and other virtues. Therefore, to suggest that people who are extremely ill can ‘do almost nothing’ overlooks an opportunity to identify ageing and illness as focal points for moral coping that takes place both before and during bodily decline. Thus the ‘doing’ Harcourt claims is limited by the absence of health may in fact be at its peak, if taken to mean moral ‘doing’, such as the cultivation of virtue, being an exemplar for others, enabling an educative process in self and others, and ‘bearing illness well’.

I would like to make three brief comments before I turn to my third and final point. First, the claim that there can be flourishing, well-being and happiness, and indeed excellence and virtue, in illness is not intended to erase, belittle or valorize illness. The grim reality of bodily failure is beyond doubt life-shattering and terrible. But the surprising fact that many ill people report some positive aspects to their lived experience of illness has so far been largely overlooked by both medicine and philosophy, to the detriment of both disciplines.

Second, the fact that illness causes only a relatively small reduction in well-being does not imply that there is less need for medical research, medical intervention, and social support for ill persons.

There are other good reasons to want to treat or prevent illness, and the fact of adaptation on its own does not entail that we ought to reduce health care resource allocation to conditions that people adapt to (Menzel et al. 2002).

Finally, I limit this discussion to physical illness, as the case of mental illness is substantively different. It is possible that absence of some extreme cases of mental illness may in fact be posited as a requirement for flourishing; and it may be that flourishing is not possible in conjunction with some mental disorders which cause extreme anguish and suffering, such as depression or anxiety. Harcourt asserts that according to Plato and Aristotle, ‘virtue is mental health and vice mental illness’, thus outlining a more intimate link between mental health and virtue than between physical health and virtue (2016, p. 233). Although this is not the focus of this paper, I would like to suggest that excellence may still be evident in at least some cases of mental disorder, for example, one courageously sharing their experiences in order to improve mental health care provision. But as a whole, I believe that mental disorders require a separate treatment to the one offered here. I therefore limit my comments in this section to somatic illness and disability, leaving the question of the relationship between mental disorder and excellence for another occasion.

IV

Excellence in Defect. Towards the end of his paper, Harcourt (2016, pp. 231–2) refers to different kinds of psychological function which are required for living in accordance with our life form. Amongst these Harcourt lists cognitive functions like memory and concentration, the ability to learn language, the capacity to form attachments, the capacity to ‘mind-read’, and the capacity to play. Although these capacities are taken to be required in order to be a ‘normal’ or ‘typical’ human being, in this section I suggest that the absence of such capacities often results in instantiations of virtue that are deep and significant, and thus require modifying Harcourt’s model.

Let us take the condition known as alcohol-related neurodevelopmental disorder (ARND), more commonly known as foetal alcohol spectrum disorder (FASD). FASD affects as many as two to five people in a hundred, and is a lifelong disability causing severe physical

and mental impairment and social, educational and adaptive deficits (May 2009). Prenatal alcohol exposure damages brain development, causing deficits in executive and cognitive function characterized by inattention, hyperactivity, impulsivity, hypervigilance and poor adaptive behaviour. It may also cause a range of physical disabilities and problems.

Despite its high incidence, its tremendous impact on children, their families, and those around them, as well as the criminal justice system and social services, and the fact that it is 100% preventable, FASD remains largely unknown, and drinking in pregnancy remains socially acceptable in many countries (Carpenter, Blackburn and Egerton 2014). Although it is common, FASD is poorly recognized by both the general population and by paediatricians and child psychiatrists, the specialists who would be consulted about the presenting symptoms (Frances 2014). It is also (partly because of its relative anonymity) notoriously hard to diagnose (Blackburn 2014).

Children with FASD spend many years, sometimes decades, being misdiagnosed and treated for other conditions (such as ADHD), being stigmatized and excluded socially and educationally, and generally having a miserable time because their disability is not recognized and they are perceived as ‘naughty’ or ‘oppositional’. For such individuals, due to deficient sensory processing and attention, and working memory deficits, reality is a bewildering place. As they perceive it, the world is noisy and unpredictable; they often don’t understand why they are being punished or reprimanded; they dive in and out of their own world, only to encounter a confusing, hostile, and opaque reality.

Because brain function varies day by day, what a person with FASD can do one day they are unable to do the next. This leads to increased misunderstanding and frustration from teachers and employers, and to the suspicion that they are deliberately avoiding demands. For the FASD-affected child or adult, too, this is bewildering. Their very own brains serve them just fine one day, only to disappoint and sabotage confidence the next. The lack of stable function can cause increasing confusion and frustration for the FASD child herself, when her own sense of bodily trust is severely disrupted by this lack of continuity (cf. Carel 2013b).

Imagine the life of a child with FASD. Every day she gets told off dozens of times for behaviours she cannot control and often does not understand or remember. Her flawed working memory causes

her to confront a request over and over again. What was I asked to do? Where did I put that paper? Why am I walking down the hall? Why am I holding scissors? Tasks are not completed because of memory and executive-function deficits, and the ensuing failure at school, at home, and in social contexts leads to an increasing sense of isolation and failure.

Let us reflect on the courage, fortitude and optimism required from such a child each morning as she gets ready for school. She knows the day will be confusing, that her experience of it will include gaps and sensory overload; she knows that others will treat her in a patronizing or impatient way, and that she will be told off for things that are beyond her control (for example, being loud when her impulse control is significantly impaired). She fears her own emotional lability, and is often frightened of what she may do and the consequences of her actions. She often does not remember or know what the day will bring, due to impaired memory (Is today Saturday? Do I have school today? What lessons are we having?). And yet, she will courageously—possibly more courageously than we can imagine—get herself ready to the best of her ability (one sock only, pyjama top still on) and set out to live another day in her bewildering, overwhelming, and often frightening reality. What excellences are exemplified by the simple act of walking out the door with her schoolbag? Perhaps these excellences are not only more numerous and more intense than those we are familiar with, but belong to a different *mode* of excellence altogether: excellence stemming from defect.

Kidd argues that we ought to relativize our conceptions of the virtues a person could cultivate to their bodily and existential situation (personal communication). For example, the virtues of creativity and adaptability I describe elsewhere (Carel 2007, 2009, 2013a) as responses to illness are ‘excellent’ responses to the lived experience of a diminishing range of bodily capacities: those virtues are inflected by the existential situation of that person and are thus contextualized by that person’s medical condition and life circumstances.

What I say about the courage of the child with FASD applies, *mutatis mutandis*, to people with physical disabilities. They too are called upon more frequently and more intensively than the healthy to display courage, patience, equanimity, tenacity, and authenticity in their life form. Those virtues, when cultivated by those persons, might be in a different mode—the courage and discipline of a

lifelong healthy person is of a different (which is not to say lesser) order than that of a terminally ill person. For example, the courage of the ill person is partly a response to an anticipated future in a way it is not for the healthy person, giving the ill person's courage a place and depth in their form of life that it lacks for the healthy.

To conclude, the bedrock assumed by Harcourt requires some re-thinking. In order for his pluralism of life forms and of human excellence to be truly plural, Harcourt must accept that in cases where some of the building blocks of his layering account may themselves be missing, excellence may have an extraordinary opportunity to display itself. I therefore suggest that his model ought to be expanded in these three ways: (i) taking a life-cycle view of the life form; (ii) recognizing edification through illness and other hardship; and (iii) including a new mode of excellence stemming from defect.¹

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