Has the fit note reduced general practice sickness certification rates?

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Background  In 2010, the fit note replaced the sick note to help focus on what people are capable of doing, rather than signing patients ‘off sick’.

Aims  To compare proportions of work-related ill-health issued with sickness certification pre-and post-fit note introduction and assess sickness absence trends.

Methods  General practitioners (GPs) report data on work-related ill-health and sickness absence via The Health and Occupation Research network in General Practice. The proportion of cases issued with sickness certification 4 years before and 3 years after the fit note introduction were compared. Changes in certification incidence rate ratios were measured over time.

Results  Participating GPs reported 5517 cases of work-related ill-health. Pre-fit note introduction 50% of cases were certified sick. There was no change in the proportion of cases certified sick in the first year post-fit note, despite 13% of cases classified as ‘maybe fit’. However, in the second year, the proportion of cases certified sick had reduced significantly (41%) and a larger proportion (19%) was advised on workplace adjustments. In the third year post-introduction, there was a slight rise in the proportion of cases certified sick; therefore, although there was a fall of 2% per annum in certification rates, this was not significant.

Conclusions  In the first year post-fit note introduction, modifications to work were recommended for people who would previously have been declared fit. Trends analyses showed a slight decrease in the certification rate, possibly indicating GPs will become more practised in advising on workplace adjustments.

Key words  Fit note; general practice; occupational health; rehabilitation; return to work; workplace adjustments.

Introduction

The cost of sickness absence to UK society in 2012 has been estimated at £14 billion per annum [1]. As well as needing to reduce the financial costs to individuals, employers and the national economy, there has been increased awareness of the importance of reducing the levels of sickness absence, through improvements in patient rehabilitation to achieve benefits in patients’ health and well-being [2]. General practitioners (GPs), as primary issuers of sickness absence certification and gatekeepers to patients’ benefits, are expected to help reduce these costs through improved training and also procedural change, such as the introduction of the Statement of Fitness for Work (fit note [3]). The fit note, introduced in April 2010, was designed to switch the focus to what people are capable of doing, rather than signing patients ‘off sick’ altogether. It was also hoped this would improve communication between employers, employees and GPs. Besides declaring a person to be fit or unfit for work, the fit note allows GPs to indicate that a person may be fit for some aspects of work [3]. GPs may suggest approaches to facilitate a return to work including phased return, altered work hours, amended duties and workplace adaptations [4]. The introduction of the fit note has been of interest to researchers within the UK and internationally [5]. Initial research evaluating GPs’ attitudes to the fit note has been positive.
A study using experimental vignettes carried out prior to the introduction indicated that a statement of fitness for work may reduce the number of patients advised to refrain from work [6] and surveys eliciting GPs' views post-introduction suggested that it improved consultations and outcomes for patients [7,8]. Other work, however, has found it may increase tension within the doctor–patient relationship [9]. In order to optimize GPs' management of sickness absence, further research is needed to quantitatively assess the effect of the fit note and the extent to which it has achieved a reduction in sickness certification. A study commissioned by the Department of Work and Pensions (DWP) collecting fit note data over a 12 month period found that 12% of fit notes issued to patients had some form of ‘may be fit for work' advice; however, this study was not able to assess whether the fit note had impacted on reducing the proportion of cases that were signed off as unfit for work [10].

The Health and Occupation Research network in General Practice (THOR-GP) is a UK-wide research network of GPs with prior training in occupational medicine [11]. This research has provided estimates of the incidence of work-related ill-health in the UK, as well as information on how GPs manage cases through sickness absence certification (and latterly workplace adjustments) and referral to other clinical practitioners [12,13]. As it collected sickness certification data prospectively for several years before the introduction of the fit note, THOR-GP provided a valuable method for a ‘before and after’ comparison of the effect of this ‘uncontrolled’ national intervention. The aims of this study were primarily to compare the proportion of cases of work-related ill-health issued with sickness certification pre- and post-fit note introduction. Additionally, analysis aimed to determine the trend in sickness certification over the 7 year study period (4 years pre-introduction and 3 years post-introduction).

**Methods**

THOR-GP is a surveillance scheme collecting information on work-related ill-health reported by 250 UK GPs with prior training to diploma level in Occupational Medicine (DipOccMed). Participating GPs report incident cases (and associated sickness absence/fit note information) as seen in their general clinical practice whenever, in their opinion, their patients’ ill-health has been caused or aggravated by work. GPs report either as ‘core’ reporters, submitting returns every month, or as ‘sample’ reporters where they submit reports for one randomly assigned month each year. In order to reduce the risk of reporter fatigue [14] and to contain costs, the proportion of ‘sample’ reporters has increased in recent years.

Participating GPs submitted cases via an on-line web form; details included demographic information, diagnosis, occupation, industry and causal agent/task/event. Prior to the introduction of the fit note with each reported case, GPs were asked to specify if sickness certification was issued, and if so, for how long. With the introduction of the fit note, the reporting form was changed to be consistent with the new form and GPs were asked whether the patient was fit for work and asked to select three options

- Yes—no further action required
- No, sickness absence certified—GPs complete the number of days absence issued
- Yes, but with workplace adjustment—GPs select from the following options
  - Phased return to work
  - Amended duties
  - Altered hours
  - Workplace adaptation
  - Other (GPs specify in text box)

Sickness certification/fit note data reported 4 years before (1 April 2006–31 March 2010) and for 3 years after the introduction of the fit note (1 July 2010–30 June 2013) were analysed (using the Pearson Chi-squared test) to assess any change in the proportion of incident cases of work-related ill-health certified sick. Analysis was repeated for ‘all cases’ and the diagnostic categories ‘musculoskeletal’, ‘mental ill-health’ and ‘other’ (including skin, respiratory and all other diagnoses). The 3 month period immediately after introduction of the fit note was treated as a ‘settling in’ period during which the GPs were expected to adjust to the new certificate and hence was not included in the study.

The trend in sickness certification over the 7 year study period was analysed using a multi-level random effects Poisson regression model fitted to the monthly data count. Each analysis was repeated under three outcomes (i) certified sick, (ii) not certified sick and (iii) issued with fit note adjustment advice. Incidence rate ratios (IRR) associated with a change were calculated, where a value of 1 indicated no change, >1 indicated an increase in the incidence rate of a particular outcome and a value between 0 and 1 represented a decrease of the IRR.

THOR (including THOR-GP) has National Health Service ethics approval given by the North West Multi-centre Research Ethics Committee (MREC 02/8/72).

**Results**

During the total study period, participating GPs reported 5517 cases of work-related ill-health to THOR-GP. The majority of these cases were musculoskeletal disorders
(2887 [51%]) and mental ill-health diagnoses (1807 [32%]). Other cases were reported as skin disease (524 [9%]), respiratory disease (128 [2%]) and ‘other’ (299 [5%]) cases categorized outwith these major diagnostic groups such as hearing loss, eye injuries, headaches, lacerations and so on. (The numbers of diagnoses are greater than the total number of cases due to reported incident comorbidity.)

Overall, there was a decrease in the proportion of cases certified sick before (50%) and after (47%) the introduction of the fit note; however, this was not significant ($\chi^2 = 3.01$, NS). As illustrated in Table 1 and Figure 1a, the first year post-fit note had the same proportion (50%) of cases certified sick as in the previous 4 years; however, in the second year of the fit note, the cases certified sick constituted a smaller proportion of the reported incident cases (41%). The proportion of cases certified sick pre-fit note was significantly different from the proportion in the second year post-fit note ($\chi^2 = 7.75, P < 0.01$). Moreover, the proportion certified sick in the second year of the fit note was significantly different than the proportion in the first year ($\chi^2 = 6.27, P < 0.05$). However, in the third year post-fit note, the proportion of cases certified sick rose slightly to 48%. There was no significant difference in the certification issued in this year compared with any other reporting period.

Diagnostic category had a significant influence on the proportion of cases that were certified sick prior to the introduction of the fit note, with cases of mental ill-health being certified sick more frequently than other work-related conditions. Results presented here show how the sickness certification issued has changed (post-fit note)

by individual diagnostic categories. The proportion of musculoskeletal disorders (before 43%, after 36%) and mental ill-health (before 76%, after 68%) certified sick fell slightly and these changes were statistically significant (musculoskeletal, $\chi^2 = 6.68, P < 0.01$; mental ill-health, $\chi^2 = 9.62, P < 0.01$). Conversely, there was an increase in the proportion of cases certified sick pre- (24%) and post- (26%) fit note for all other cases (including skin, respiratory and ‘other’); however, this was not significant. Compared with other diagnoses, psychological cases were less likely to be recommended a workplace adjustment: that is, 6% of cases compared with 21% musculoskeletal and 23% of other cases (Tables 2–4 and Figure 1b–d).

The trends analysis (though non-significant in all cases) indicated a general decrease in the number of cases certified sick as the study year increases; conversely, the number of cases not certified sick or given fit note workplace adjustment advice (i.e. considered fit for work) increases. In all cases, except ‘other’ diagnoses, the incidence rate of cases certified sick decreases by 2% as study year increases. For these ‘other’ diagnoses, the change in incidence rate is larger with a fall of 12% per year. Post-fit note introduction, there appeared to be an increase in the total number of cases certified sick (IRR = 1.03); however, this is likely to be due to the larger IRR associated with the ‘other’ diagnoses, as both musculoskeletal and mental ill-health see a decrease (11 and 4%, respectively). The rate of GPs issuing workplace adjustment advice has increased consistently (IRR = 1.12) in all diagnoses except mental ill-health, which indicates a decrease over the 3 years of 12% per year.

Table 1. Proportionate comparison of sickness absence certification by GPs reporting new cases (all cases) of work-related ill-health for 4 years before the introduction of the fit note in April 2010 and for 3 years afterwards

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<tbody>
<tr>
<td>Cases certified sick, n (%)</td>
<td>774 (52)</td>
<td>604 (49)</td>
<td>583 (51)</td>
<td>384 (47)</td>
<td>2345 (50)</td>
<td>187 (50)</td>
<td>99 (41)</td>
<td>105 (48)</td>
<td>391 (47)</td>
</tr>
<tr>
<td>Cases NOT issued with sickness certification, n (%)</td>
<td>720 (48)</td>
<td>625 (51)</td>
<td>556 (49)</td>
<td>436 (53)</td>
<td>2337 (50)</td>
<td>139 (37)</td>
<td>98 (41)</td>
<td>76 (35)</td>
<td>313 (38)</td>
</tr>
<tr>
<td>Cases advised fit for work with fit note adjustment recommended, n (%)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>48 (13)</td>
<td>45 (19)</td>
<td>38 (17)</td>
<td>131 (16)</td>
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<tr>
<td>Total cases reported, n (%)</td>
<td>1494 (100)</td>
<td>1229 (100)</td>
<td>1139 (100)</td>
<td>820 (100)</td>
<td>4682 (100)</td>
<td>374 (100)</td>
<td>242 (100)</td>
<td>219 (100)</td>
<td>835 (100)</td>
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The number of actual cases varied by year because of the changes in the sampling frame.
Discussion

The results presented here showed that there was little change in the proportion of patients who were declared unfit for work in the first year post-fit note introduction. There was, however, a significant reduction in cases certified sick after 2 years of fit note use. These results suggest that in the first year, workplace modifications were recommended for people previously declared fit. In the second year post-fit note, a larger proportion of cases were given workplace adjustment advice, complemented by a reduction in the proportion of cases certified sick suggesting GPs became more practised and confident in advising on workplace adjustments. There was a slight rise in the proportion of cases issued with sickness certification in the third year post-fit note introduction; however, over the 7 year study period, trend analysis showed that there was a (non-significant) decrease in cases certified sick and an increase in cases given workplace adjustments advice.

THOR-GP is a UK-wide surveillance scheme; basic comparisons of the distribution of participants with UK
GPs suggest THOR-GPs are geographically representative \[11,15\]. However, GPs are only eligible to participate if they have been trained to diploma (DipOccMed) level. It is estimated that only 4% of UK GPs have this training; therefore, this group of GPs may differ slightly in their clinical practice to GPs chosen at random \[16,17\]. THOR-GPs may have already been practising with more optimal effectiveness in respect of rehabilitation back to work than other GPs and the fit note merely gave them a better opportunity of documenting their previous practice. Nevertheless, the increase in the proportions of fit note recommendations in the second year suggests there was still capacity for improvement. Research has shown that GPs working part-time in occupational medicine clinics (as do many THOR-GPs) issue shorter periods of absence \[18\]. Research has shown that these THOR-GPs perceive that their training in occupational medicine may alter their outlook in relation to health and work \[13\]. Surveys have shown that the majority of GPs had not received any training in sickness certification and that GPs are inconsistent in recording employment information in patient records \[8,19,20\]. Specifically, they did not feel confident in using the fit note tick box options and do not often add information in the comment box of ‘may be fit’ cases \[7,10\].

**Table 2.** Proportionate comparison of sickness absence certification by GPs reporting new cases of work-related musculoskeletal disorders for 4 years before the introduction of the fit note in April 2010 and for 3 years afterwards

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<tbody>
<tr>
<td>Cases certified sick</td>
<td>351 (43)</td>
<td>289 (43)</td>
<td>278 (46)</td>
<td>162 (39)</td>
<td>1080 (43)</td>
<td>63 (38)</td>
<td>41 (35)</td>
<td>33 (34)</td>
</tr>
<tr>
<td>Cases NOT issued with sickness certification</td>
<td>459 (57)</td>
<td>389 (57)</td>
<td>325 (54)</td>
<td>254 (61)</td>
<td>1427 (57)</td>
<td>71 (43)</td>
<td>52 (44)</td>
<td>39 (41)</td>
</tr>
<tr>
<td>Cases advised fit for work with fit note adjustment recommended</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>32 (19)</td>
<td>25 (21)</td>
<td>24 (25)</td>
</tr>
<tr>
<td>Total cases reported</td>
<td>810 (100)</td>
<td>678 (100)</td>
<td>603 (100)</td>
<td>416 (100)</td>
<td>2507 (100)</td>
<td>166 (100)</td>
<td>118 (100)</td>
<td>96 (100)</td>
</tr>
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**Table 3.** Proportionate comparison of sickness absence certification by GPs reporting new cases of work-related mental ill-health for 4 years before the introduction of the fit note in April 2010 and for 3 years afterwards

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<tbody>
<tr>
<td>Cases certified sick</td>
<td>369 (80)</td>
<td>271 (74)</td>
<td>270 (74)</td>
<td>212 (76)</td>
<td>1122 (76)</td>
<td>113 (71)</td>
<td>52 (63)</td>
<td>63 (68)</td>
</tr>
<tr>
<td>Cases NOT issued with sickness certification</td>
<td>94 (20)</td>
<td>93 (26)</td>
<td>95 (26)</td>
<td>68 (24)</td>
<td>350 (24)</td>
<td>37 (23)</td>
<td>26 (32)</td>
<td>25 (27)</td>
</tr>
<tr>
<td>Cases advised fit for work with fit note adjustment recommended</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>10 (6)</td>
<td>4 (5)</td>
<td>5 (5)</td>
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<tr>
<td>Total cases reported</td>
<td>463 (100)</td>
<td>364 (100)</td>
<td>365 (100)</td>
<td>280 (100)</td>
<td>1472 (100)</td>
<td>160 (100)</td>
<td>82 (100)</td>
<td>93 (100)</td>
</tr>
</tbody>
</table>
Table 4. Proportionate comparison of sickness absence certification by GPs reporting new cases of other work-related diagnoses (e.g. skin, respiratory and so on) for 4 years before the introduction of the fit note in April 2010 and for 3 years afterwards

<table>
<thead>
<tr>
<th>Cases certified sick, n (%)</th>
<th>1 April 2006–31</th>
<th>1 April 2007–31</th>
<th>1 April 2008–31</th>
<th>1 April 2009–31</th>
<th>Total pre-fit note</th>
<th>1 July 2010–30</th>
<th>1 July 2011–30</th>
<th>1 July 2012–30</th>
<th>Total post-fit note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases NOT issued with sickness certification, n (%)</td>
<td>180 (73)</td>
<td>159 (75)</td>
<td>149 (75)</td>
<td>123 (87)</td>
<td>611 (76)</td>
<td>34 (61)</td>
<td>22 (47)</td>
<td>15 (42)</td>
<td>71 (51)</td>
</tr>
<tr>
<td>Cases advised fit for work with fit note adjustment recommended, n (%)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>7 (12)</td>
<td>16 (34)</td>
<td>9 (25)</td>
<td>32 (23)</td>
</tr>
<tr>
<td>Total cases reported, n (%)</td>
<td>247 (100)</td>
<td>212 (100)</td>
<td>200 (100)</td>
<td>142 (100)</td>
<td>801 (100)</td>
<td>56 (100)</td>
<td>47 (100)</td>
<td>36 (100)</td>
<td>139 (100)</td>
</tr>
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</table>

This study is related specifically to work-related illness. There are likely to be differences in the way GPs manage these conditions. A lower proportion of ‘all cause’ cases (i.e. not just those specified as work-related) are certified sick [21,22]. For work-related musculoskeletal and mental ill-health cases (pre-fit note), 43% and 76% of cases were certified sick, respectively, whereas for ‘all cause’ conditions fewer patients were certified sick (musculoskeletal 30%, mental ill-health 36% [21,22]), suggesting work-relatedness has a greater impact on sickness absence rates of psychological conditions compared with musculoskeletal diagnoses. Previous work has shown how the psychosocial work environment can predict sickness absence rates [23]. GPs were less likely to recommend a return to work if they felt that the patient’s job contributed to their ill-health [8]. However, a survey of DWP line managers suggested that ~10 to 15% (of all cause cases) were issued with a ‘may be fit’ recommendation, similar to the results shown here [24]. The 2013 DWP report states that 12% of patients issued fit notes were assessed as ‘may be fit’ [10]. Post-fit note 16% of cases were reported by THOR-GPs as ‘may be fit’. However, it should be noted that the DWP study did not include those considered fit for work, whereas this study is based on all cases. To make a more meaningful comparison, 25% of THOR-GP cases issued with a fit note were classed as ‘may be fit’, much higher than the 12% described in the DWP study; likely due to the work-relatedness of the cases and/or participating GPs training.

GPs contributing to research [7] felt that over time they may be able to use the fit note more beneficially. This was not shown in the DWP study, where fit notes with return to work advice fell proportionally from 7.3 to 5.5% (and then increased to 6.6% [10]). In the analysis presented here, the proportion of cases given workplace adjustment advice increased; however, similarly to the DWP study, the pattern is unclear (13, 19 and 17%). The prospective nature of THOR-GP will permit the continuing investigation of this temporal trend.

There is little information on fit note use in the workplace. A study of both employers and employees found that both parties viewed this change to the sickness certification system positively [25]. Employing organizations questioned in a DWP qualitative report [26] felt that sickness absence had been influenced by focusing on return to work, and empowered them in negotiations with employees but that fitness for work advice can be hindered by GPs’ lack of information about job roles and occupational health. The 2011 Confederation of British Industry (CBI) survey [27] also stated that the fit note was welcomed by employers; however, two-thirds of firms surveyed felt it had ‘not moved things forward’. Moreover, 13% of employers felt that GPs lacked the training to use the fit note adequately. A sickness absence review [24] found that employers commonly stated that the certification system had yet to meet their needs, that few fit notes described an employee as ‘may be fit’ and advice given was not considered particularly helpful.

Some have argued that the ‘jury is still out’ on the utility of the fit note and GP views are mixed [28]. This study has shown that initially the fit note (for work-related ill-health) had little effect on the proportion of patients certified sick. Subsequently, there appeared to have been some reduction in the proportion of patients certified sick. Results showed that workplace adjustments were rarely given for cases of work-related psychological conditions, which are more often multi-factorial in nature and problematic when attempting to identify specific workplace exposures. This was also the case for mental ill-health disorders in other research [10] and
underlines the need for further training in the management of mental ill-health especially if work-related. With increased awareness, training and promotion, the fit note may prove to be a useful consultation tool in keeping patients in work and might help to avoid the patient’s ill-health developing into long-term sickness and permanent worklessness [2,29].

This study is based on a fairly small number of cases and results have to be considered accordingly; however, the collation of this information is on-going and analysis of further data will improve robustness and allow an assessment of how the use of the certificate may improve with time. As yet it is unknown how the fit note is being used by the employer, and therefore whether the patients with recommended adjustments remain at work or end up having time off sick. The sickness absence information reported by THOR-GP participants is continuously audited. In order to assess the accuracy of the longitudinal sickness absence information submitted, a year retrospectively, GPs are asked how long a patient was certified sick in total. This retrospective information is also now collected on ‘may be fit’ cases to establish whether the patient remained at work due to the GPs recommended adjustments.

Key points

• This study illustrates how the introduction of the fit note has affected the proportion of cases of work-related ill-health that were issued with sickness certification through the collection of prospective incident case data.
• After the introduction of the fit note, general practitioners recommended workplace adjustments in a proportion of patients who would previously have been declared fit for work; in the second year of fit note use, there was a small but significant reduction in the proportion of the cases issued with sickness absence certification; however, this fall in certification rate was not shown in the third year post-introduction.
• Workplace adjustments were less likely to be recommended for cases of work-related mental ill-health, which are often complex and multi-factorial in nature, underlining the need for further training in the management of mental ill-health especially if work-related.

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Acknowledgements

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Conflicts of interest

None declared.

References

Towards the end of the First World War, the average life expectancy of a pilot at the Western Front was around 17 days [1]. There was concern that medical unfit- ness was contributing to the attrition rate. A conference to discuss the issues was held on 27th February 1917, chaired by Fleet Surgeon R. C. Munday, RN, soon to be appointed the first head of the RAF Medical Service. The conference concentrated on the symptoms of high flying, acclimatization and the use of oxygen equipment as well as the development of medical standards for pilots. The studies that followed led to the publication of The Medical Problems of Flying after the war, which focused on hypoxia and the psychological aspects of aviation but did not address protection against gravitational forces (g) applied in the head to foot direction (g). Although Head [2] described greying out, blacking out and even possible loss of consciousness during aerobatic manoeuvres, he reported considerable variation between pilots, and the only suggestion made was that the problems could be overcome by adaptation and experience.

However, in discussion following a meeting of the Medical Society of London in early 1918 [3], Munday drew attention to the importance of the posture of the aviator during a steep spiral. He stated that in the usual upright position, ‘the centrifugal action must seriously affect the cerebral blood pressure’. He went on to suggest that if the pilot ‘leans back as far as possible centrifugal action on the brain’ would be ‘almost nil’. Development of g protection in the UK was not really considered until the 1930s. From then on, research concentrated successively on muscle tensing, abdominal belts, raising the rudder pedals, the development of air- and fluid-filled anti-g suits and, for a time, prone position aircraft.

Munday’s practical comments appear to have been the first published advice on g protection. However, possibly because he only lasted 6 months in his role as head of the new RAF Medical Service, the suggestion proved to be a cul de sac in the road to g protection until, independently, the Americans designed the ACES II ejection seat for the F-16 with a seat back angle of 30° in the 1970s. How did Munday, a career Naval doctor with no experience of flying, know about g? His son, R. B. Munday, flew Sopwith Camels in the Royal Naval Air Service and was a recognized ‘ace’, holding the Distinguished Service Cross. This gives a different slant to the adage that it is not what you know but who you know that counts.

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References