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The Premortem Technique

Abstract
[Excerpt] An autopsy—aka a postmortem examination—is a specialized surgical procedure conducted by a pathologist to thoroughly assess a corpse to determine or confirm the exact cause and circumstances of death or the character and extent of changes produced by disease.

Knowledge is what you harvest from experience—be that your own or someone else's—through sense-making. In sundry areas of human endeavor, it is common (but not common enough) to conduct the equivalent of a post-mortem by means of formal completion or evaluation reports—after-action reviews, retrospects, and learning histories are rarer still—to try to understand why an initiative did or did not succeed. And so, except in learning organizations, lessons (to be) learned mostly eventuate in the form of hindsight—that, by and large, focusing on accountability, not learning—at the (wrong) end of a plan. Paraphrasing Karl Marx, this is why history repeats itself: the first time as tragedy, the second time as farce.

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Comments
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Knowledge Solutions

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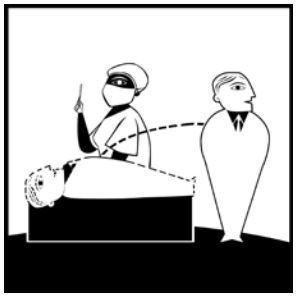
The Premortem Technique

By Olivier Serrat

Assumptions that do not associate with probabilities create a false sense of certainty. Working backward, considering alternatives that emerge from failed assumptions broadens the scope of scenarios examined. The Premortem technique raises awareness of possibilities, including their likely consequences, to enrich planning.

Why History Repeats Itself



An autopsy—aka a postmortem examination—is a specialized surgical procedure conducted by a pathologist to thoroughly assess a corpse to determine or confirm the exact cause and circumstances of death or the character and extent of changes produced by disease.

Knowledge is what you harvest from experience—be that your own or someone else's—through sense-making.[1] In sundry areas of human endeavor, it is common (but not common enough) to conduct the equivalent of a postmortem by means of formal completion or evaluation reports—after-action reviews, retrospects, and learning histories are rarer still—to try to understand why an initiative did or did not succeed. And so, except in learning organizations, lessons (to be) learned mostly eventuate in the form of hindsight—that, by and large, focusing on accountability, not learning—at the (wrong) end of a plan.[2] Paraphrasing Karl Marx, this is why history repeats itself: the first time as tragedy, the second time as farce.

> *You got to be careful if you don't know where you're going, because you might not get there.*
>
> —Yogi Berra

> *To consult the statistician after an experiment is finished is often merely to ask him to conduct a postmortem examination. He can perhaps say what the experiment died of.*
>
> —Ronald Fisher

[1] To engage in sense-making is to exploit information for awareness, understanding, and planning to make faster and better decisions.

[2] Depending on the context, just-in-time opportunities to identify, create, store, share, and use knowledge can of course arise before and during a situation, not only after it has come to pass. To note, projects and programs, but also the policies, strategies, and partnerships that underpin them, are developed in response to the existence of a perceived opportunity or problem: they do not exist in a vacuum. (Therefore, the external environment—not to mention the specific organizational knowledge, inter- and intra-organizational relationships, and organizational context of the parties that formulate them—is very important because it will shape the kinds of actions considered.) However, because change is the only constant, ongoing monitoring and evaluation must be integrated into the implementation of projects, programs, etc. and co-evolve with emergence. Otherwise, as so often happens, managers will find that their activities are judged ex-post by methods and associated data requirements that were never built into the original endeavor. The chance to learn powerful lessons before and during the activities will have been lost and the value of those promulgated after them will most likely be lesser.

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On Safe Silence, Bias, and Dissent

Does the following development seem familiar? A proposal is drawn by a task force, endorsed by decision makers, approved by senior management, launched with fanfare, but leads nowhere. Why? There are two explanations. In bureaucratic organizations—and not only during planning but also across their operations—people are reluctant to express reservations about the workability of a plan: they keep mum because it can be dangerous to oppose what bosses—mark, not managers—command. Cognitive barriers play a role too: individuals and groups may be biased; when they have worked hard on a plan they can also become psychologically committed to the idea of success, be overconfident, and therefore blind to some of its risks. (Bias[3] is the inclination to present or hold a partial perspective at the expense of possibly equally valid alternatives. A related, prevalent phenomenon, groupthink, refers to the mode of thinking that happens when the desire for harmony in a decision-making group overrides a realistic appraisal of options.)

> *When personal judgment is inoperative (or forbidden), men's first concern is not how to choose, but how to justify their choice.*
>
> —Ayn Rand

Analysis is an exercise in judgment under conditions of uncertainty, and the errors in judgment we make, singly or in groups, in a day or through life, are countless. In organizational settings, especially in complicated, complex, or, chaotic situations, a dependable measure might be—as Daniel Kahneman et al. intimate but do not underscore—to legitimize early dissent and quickly place creative, contrarian[4] objections and suggestions on the table to reinforce the decision-making process and thereby improve a plan's chances of success before it stalls, peters out, or backfires.

> *In the space of two days I had evolved two plans, wholly distinct, both of which were equally feasible. The point I am trying to bring out is that one does not plan and then try to make circumstances fit those plans. One tries to make plans fit the circumstances.*
>
> —George Patton

There's No Risk of Accident for Someone Who's Dead

Enter, thanks to Gary Klein,[5] the Premortem technique:[6] based on a process known as reframing,[7] this risk-mitigation planning tool attempts to identify threats at the outset. Specifically, it helps challenge key assumptions, generate multiple hypotheses, discover unknown unknowns, track alternative future trajectories, and anticipate the unanticipated. For sure, by testing, probing, and even attacking individual and collective mindsets, greater rigor in critical thinking can reduce the chance of (unpleasant) surprises.

A premortem is the imaginary converse of an autopsy; the hindsight this intelligence assessment offers is prospective. In sum, tasking a team to imagine that its plan has already been implemented and failed miserably increases the ability of its members to correctly identify reasons for negative future outcomes. This is because

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[3] Bias comes in many forms. Daniel Kahneman, Dan Lavalo, and Olivier Sibony recommend that the proponents of a plan should check for (i) self-interested biases; (ii) affect heuristic; (iii) groupthink; (iv) saliency bias; (v) confirmation bias; (vi) availability bias; (vii) anchoring bias; (viii) halo effect; and (ix) sunk-cost fallacy, endowment effect. The challenge questions associated with each bias that they helpfully pose are, respectively, as follows: (i) Is there any reason to suspect the team making the recommendation of errors motivated by self-interest? (ii) Has the team fallen in love with its proposal? (iii) Were there dissenting opinions within the team? Were they explored adequately? (iv) Could the diagnosis be overly influenced by an analogy to a memorable success? (v) Are credible alternatives included along with the recommendation? (vi) If you had to make this decision again in a year's time, what information would you want, and can you get more of it now? (vii) Do you know where the numbers came from? Can there be unsubstantiated numbers, extrapolation from history, or a motivation to use a certain anchor? (viii) Is the team assuming that a person, organization, or approach that is successful in one area will be just as successful in another? (ix) Are the recommenders overly attached to a history of past decisions? See Daniel Kahneman, Dan Lavalo, and Olivier Sibony. 2011. Before You Make That Big Decision … *Harvard Business Review*. June. pp. 51–60.

[4] The Devil's advocate was a function and office introduced by the Roman Catholic Church in the 16th century to take a skeptical view of proposals for the canonization of a candidate. The canon lawyer appointed would oppose God's advocate, whose task was to make the argument in favor of canonization. In common parlance, a devil's advocate is someone who takes a position he or she does not necessarily agree with to test the quality of an argument and help improve or force the withdrawal of the original proposal.

[5] Gary Klein. 2007. Performing a Project Premortem. *Harvard Business Review*. September. pp. 18–19.

[6] The technique is reminiscent of Disaster Charting, a method that—itself in the vein of the Five Whys technique—endeavors through repeated questioning to map post hoc a fault tree of precursors that might have contributed to an accident.

[7] Reframing holds that insights can be gained simply by looking at a situation from a different perspective, or in a different context, than one is accustomed to. The Reframing Matrix and the Six Thinking Hats technique are two methods to achieve this.

taking a team out of the context of defending its plan and shielding it from flaws opens new perspectives from which the team can actively search for faults.[8] Despite its original high level of confidence, a team can then candidly identify multiple explanations for failure, possibilities that were not mentioned let alone considered when the team initially proposed then developed the plan. The expected outcomes of such stress-testing are increased appreciation of the uncertainties inherent in any projection of the future and identification of markers that, if incorporated in the team's design and monitoring framework and subsequently tracked, would give early warning that progress is not being achieved as expected.

> *Live as if you were to die tomorrow. Learn as if you were to live forever.*
>
> —Mohandas K. Gandhi

The Premortem technique is low cost and high payoff. Its application is straightforward and need not take more than 1 or 2 hours, preferably with the help of a facilitator:

- Settle on a period, in months or years, after which it might be known whether a plan was well formulated. Imagine the period has expired: the plan is a fiasco and has spawned dire consequences; what could have caused this?
- Request each team member to suggest 10 reasons for failure, particularly those he or she would never bring up for fear of being impolite—sensitive issues might be divulged anonymously. Reasons can also be found in the external environment, not just the organizational context, organizational knowledge, and inter- and intra-organizational relationships to which priority attention is habitually given. Starting with the team leader, ask each team member to voice one reason from his or her list. Everyone should mention a reason in turn until all have been revealed and recorded.
- After the session is over, gather and prioritize the comprehensive list of reasons that grew out of collective knowledge.
- Look for ways to strengthen the plan by avoiding or mitigating essential drivers of failure, beginning with the two or three items deemed of greatest concern.

Figure: Conducting a Premortem

Source: Author.

Some may worry the Premortem technique could lead to situations where opposition so threatens a plan it must be abandoned. (The rejoinder to this is that a plan should indeed be ditched if the objections to it are that strong.) However, common sense suggests that a plan would be modified for the better, not abandoned, in most instances.

[8] What might go wrong? What might be the cause? What might we do to prevent the problem from happening? What might we do if the problem does occur? These questions, which in real life beggar interest when they do not try our patience, have reached their sell-by date. Instead, we must assume that a compelling worst-case scenario detailing embarrassing organizational malfunction took place. Thus, by establishing the certainty that a fiasco has actually occurred—thus preempting equivocations of likelihood—the Premortem technique rectifies the predilection that individuals and groups have for scenario development by forcing a focus on scenario analysis.

Further Reading

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Asian Development Bank

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