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Research Article

Assessment of medical healthcare occupations suitability applying the Holland RIASEC model using FIKR (facet, insight, knowledge, and resilience) profiling assessment tool

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Background: Healthcare and social helping occupations require not only technical competence but also interpersonal, creative, and leadership capacities that match the social and organizational complexity of these roles. Aligning personality traits with occupational demands can improve workforce stability, patient care quality, and job satisfaction. The Holland RIASEC model, combined with detailed personality profiling, provides a useful framework for this alignment. To evaluate the suitability of 130 individuals for medical and social helping occupations using the Holland RIASEC model together with the FIKR (Facet, Insight, Knowledge, and Resilience) profiling tool, with emphasis on the Social, Artistic, Enterprising, and Conventional dimensions.

Method: Participants completed a 200 item dichotomous questionnaire that mapped FIKR facets to the six RIASEC dimensions. “High” scores were defined empirically as scores in the top quartile of the observed distribution for each dimension. Because scores are discrete, ties at the cut off can produce proportions greater than 25%. Descriptive statistics were computed, and exploratory chi square tests and correlations were planned to add interpretive depth.

Results: Using the empirical top quartile cut offs, 50 individuals (38.5%) met the social threshold, 45 (34.6%) met the Artistic threshold, 38 (29.2%) met the Enterprising threshold, and 55 (42.3%) met the Conventional threshold. These subsets indicate interpersonal strength, creative potential, leadership inclination, and preference for structure, respectively.

Conclusion: A percentile based classification yields transparent and reproducible identification of high scoring subgroups relevant to healthcare and social helping work. The approach can inform recruitment, role placement, and targeted training for patient facing, creative, administrative, and leadership functions.

Keywords: *Holland RIASEC, FIKR profiling, healthcare workforce, personality assessment, helping professions*

Introduction

The alignment between individual personality traits and occupational roles has been extensively studied in the field of vocational psychology. One of the most widely recognised frameworks for understanding this alignment is the Holland RIASEC model, which categorises occupations into six major personality types: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (Elam, 1994). This model provides a structured approach to career counselling by matching individuals' dominant personality traits with suitable occupational environments (Deng et al., 2007). Recent applications of the model have extended into healthcare, where studies have demonstrated its effectiveness in identifying personality-based alignment with medical specialties and organisational roles (Woods et al., 2016). Healthcare and social helping professions are experiencing rising demands due to demographic changes, evolving patient expectations, and the integration of new technologies into care delivery. These occupations require not only technical competence but also a high degree of empathy, interpersonal skills, creativity, and the ability to function in structured systems. Misalignment between personality and role demands has been linked to higher burnout rates, reduced job satisfaction, and poorer service quality (Kil et al., 2024; Schillaci et al., 2024). Social and helping occupations are particularly significant in today's society, where the demand for skilled professionals in healthcare, education, counselling, and social work continues to grow. The Social (S) dimension of the Holland RIASEC model specifically addresses the interpersonal orientation, empathy, and communication skills that underpin such roles. Studies have shown that healthcare providers with stronger Social and Enterprising orientations tend to demonstrate more effective patient-centred care and collaborative team behaviour (Karl et al., 2007; Veerasamy et al., 2015). Furthermore, individuals in healthcare settings who possess traits such as emotional intelligence and social awareness exhibit superior decision-making and leadership qualities (Sedlár & Gurňáková, 2025; Di Fabio & Palazzeschi, 2012). By analysing the personality profiles of 130 respondents, this study aims to identify those who exhibit strong social traits and are therefore well suited for helping professions. The importance of this identification is supported by recent evidence showing that healthcare workers' personalities are significantly correlated with patient service quality and interprofessional communication effectiveness (Komari & Djafar, 2023; Schätzle et al., 2024). Personality traits have also been found predictive of safety attitudes, job satisfaction, and resilience against burnout in high-pressure medical environments (Kil et al., 2024; Guglielmi et al., 2019). Previous research consistently shows that individuals whose personality traits align with their occupational environment tend to experience higher job satisfaction, better performance, and lower levels of stress (Woods & Barratt, 2018). This is particularly true in social and helping professions, where emotional demands can lead to burnout if there is a mismatch between an individual's personality and their role. Moreover, gender differences in personality profiles have been observed among healthcare providers, especially in leadership positions, suggesting the need for nuanced personality–role alignment strategies (Barrett, 1994). In this study, the analysis of respondents' RIASEC scores focuses on identifying those with high Social (S) scores, along with supporting traits such as Enterprising (E) and Artistic (A). These complementary traits can enhance suitability for specific helping professions, whether in direct patient care, educational settings, or community outreach. The integration of the Holland RIASEC model with the FIKR (Facet, Insight, Knowledge, and Resilience) profiling tool offers a robust, data-driven framework for understanding how personality patterns align with the diverse demands of medical healthcare and social helping occupations.

Materials and methods

Participants, Sampling, and Representativeness

The dataset consisted of 130 valid responses from an initial pool of 250 cases provided by Humanology Sdn Bhd. Inclusion criteria were age 18 or above, full completion of all questionnaire items, and consent for anonymised use. Exclusion criteria were incomplete responses, duplicate entries, or patterned responding. The sample comprised 72 females and 58 males, aged 20 to 55 years. Participants represented diverse occupational backgrounds relevant to helping professions. Recruitment was convenience based through organisational outreach. No demographic stratification was applied, so generalisation beyond similar populations should be made with caution. Sample size justification: A final sample of 130 exceeds common rules of thumb for profile based and correlational work in vocational psychology and supports stable estimation of proportions and correlations (Gorsuch, 1983; Tabachnick & Fidell, 2019).

Instruments and Validation

A 200 item dichotomous questionnaire mapped FIKR facets to RIASEC dimensions as follows: Realistic included Endurance, Variety, and Aggressive; Investigative included Self-criticism, Analytical, and Intellectual; Artistic included

Intuition, Emotional, and Perceiver; Social included Dependent, Nurturance, and Extrovert; Enterprising included Extrovert, Achievement, and Control; Conventional included Support, Structure, Self conceptual, and Autonomy.

Internal consistency was evaluated using Cronbach's alpha at the dimension level and met conventional criteria for acceptable reliability as recommended by Nunnally & Bernstein (1994). The instrument has been used in applied counselling contexts in Malaysia and is appropriate for exploratory workforce alignment.

Integration of FIKR and RIASEC

Each RIASEC dimension score was computed as the unweighted sum of its mapped FIKR facets. The mapping reflects conceptual alignment between facets and Holland types as used in vocational psychology. This integration allows interpretation of occupational tendencies together with trait expressions that are pertinent to healthcare and social helping work.

Scoring and Empirical High Score Thresholds

High scores were defined empirically as scores at or above the seventy fifth percentile of the observed distribution for each dimension in this sample. Because scores are discrete, ties at the cut off can lead to proportions greater than 25%. The resulting thresholds were Social 25 or higher, Artistic 21 or higher, Enterprising 23 or higher, and Conventional 31 or higher. Counts and percentages that follow refer to respondents meeting or exceeding these cut offs.

Data Analysis

Descriptive statistics were computed for each dimension including range, mean, and percentage meeting high thresholds. Exploratory chi square tests were planned to examine associations between high score status and basic demographics.

Ethical Considerations

This secondary analysis used anonymised organisational data provided with consent. The study involved minimal risk and was exempted from full institutional review under local guidelines. The work followed the principles of the Declaration of Helsinki.

Results

Plant height and stem diameter of cauliflower

Table 1 summarises distributions and the number meeting empirical high thresholds. Score ranges are shown using the observed minima and maxima. The percentages represent the share of respondents at or above the top quartile cut off for each dimension.

Table 1. A summary of the distribution of respondents' scores across the RIASEC dimensions , using FIKR profiling assessment tool, based on 130 respondents.

No.	Dimension	Score Range	Average Score	Number of Individuals	Percentage of Respondents	Description
1	Realistic (R)	14-30	22.5	40	30.80%	Lower inclination towards practical, hands-on tasks, suggesting suitability for roles not heavily reliant on physical or technical skills.
2	Investigative (I)	8-28	18.9	35	26.90%	Lesser preference for analytical and problem-solving tasks, indicating suitability for roles that emphasize interpersonal interaction and support.

3	Artistic (A)	12-29	16.4	45	34.60%	Strong potential for creative approaches in social and helping professions, such as therapy or community engagement.
4	Social (S)	15-30	22.5	50	38.50%	High preference for working with and helping others, indicating suitability for careers in social work, counseling, teaching, and healthcare.
5	Enterprising (E)	10-30	20.4	38	29.20%	Potential for leadership roles within social and helping professions.
6	Conventional (C)	11-39	29.6	55	42.30%	Preference for structured environments, indicating suitability for roles in healthcare management or social service administration.

Note: High score cut offs defined as the seventy fifth percentile of the observed distribution per dimension. Because of ties at cut offs, proportions can exceed 25%.

Realistic (R) dimension

Scores in the Realistic dimension ranged from 14 to 30, with a mean of 22.5. Forty respondents (30.8%) met or exceeded the high-score threshold. These individuals demonstrated relatively greater comfort with practical, hands-on, or task-oriented activities compared to their peers. However, the overall description in Table 1 suggests that many respondents do not prioritise physically intensive or technical tasks, making them more inclined toward roles that emphasise interpersonal, creative, or administrative responsibilities rather than purely mechanical or outdoor work.

Investigative (I) dimension

Investigative scores ranged from 8 to 28, with a mean of 18.9. Thirty-five respondents (26.9%) met the high-score threshold. Those in this subset showed stronger analytical, problem-solving, and research-oriented tendencies. Still, the lower average across the full sample indicates that a majority are less inclined toward roles requiring prolonged analytical focus, suggesting that their strengths may lie in more people-centred or operational tasks rather than laboratory or diagnostic specialisations.

Artistic (A) dimension

Artistic scores ranged from 12 to 29, with a mean of 16.4. Forty-five respondents (34.6%) reached the high-score threshold of 21 or more. This relatively large high-scoring group points to a notable creative potential within the sample. Such creativity could be harnessed in therapeutic interventions, community engagement initiatives, or health education campaigns, where innovative problem-solving and expressive communication are valued.

Social (S) dimension

The Social dimension, which reflects interpersonal orientation and empathy, ranged from 15 to 30, with a mean of 22.5. Fifty respondents (38.5%) scored at or above the high threshold of 25. This was the largest high-scoring subgroup across all six dimensions, indicating that more than one-third of the sample exhibits strong tendencies toward roles involving direct interaction, emotional support, and service to others - qualities critical to careers in social work, counselling, healthcare, and teaching.

Enterprising (E) dimension

Enterprising scores ranged from 10 to 30, with a mean of 20.4. Thirty-eight respondents (29.2%) achieved high-score status (≥23). High scorers in this domain show a greater likelihood of thriving in roles requiring initiative-taking,

persuasion, and organisational leadership. Their traits may support supervisory or managerial responsibilities in healthcare and social service organisations.

Conventional (C) dimension

Conventional scores had the widest range, from 11 to 39, with a mean of 29.6. Fifty-five respondents (42.3%) scored at or above the high threshold of 31, making this the largest high-scoring group in the sample. This indicates a strong preference for structure, routine, and adherence to procedures. In healthcare and social helping contexts, such traits are valuable for maintaining standards, ensuring compliance, and overseeing administrative processes.

Discussion

Social orientation and patient facing roles

Using empirical cut offs based on the top quartile of the observed distribution, the social dimension had the largest high scoring subset in this sample. A total of 50 of 130 respondents met or exceeded the social threshold of 25, which corresponds to 38.5%. Ties at the cut off explain why this share is greater than 25%. The Social scale also showed a relatively high mean of 22.5. These results indicate a sizeable group with interpersonal and empathic tendencies that align with patient facing care, counselling, and community outreach. The Social domain in the Holland RIASEC model captures preference for helping, caring, and supportive roles, traits that are central to effective clinical interaction and service delivery (Deng et al., 2007; Woods et al., 2016).

Figure 1. displays the overall personality profile alongside illustrative healthcare occupations. Prior work links stronger social orientation and socio emotional skills with trust building, clear communication, and collaborative practice, all of which support patient centred care and team effectiveness in healthcare settings (Duffy et al., 2009; Woods et al., 2016; Di Fabio & Palazzeschi, 2012). Evidence from medical and health professional education further shows that students and practitioners who report higher empathy, self-efficacy, and communication skills tend to function better in clinical placements and team based environments, reinforcing the practical value of Social scores for role matching and training design (Nasir et al., 2011; Sedlár & Gurňáková, 2025).

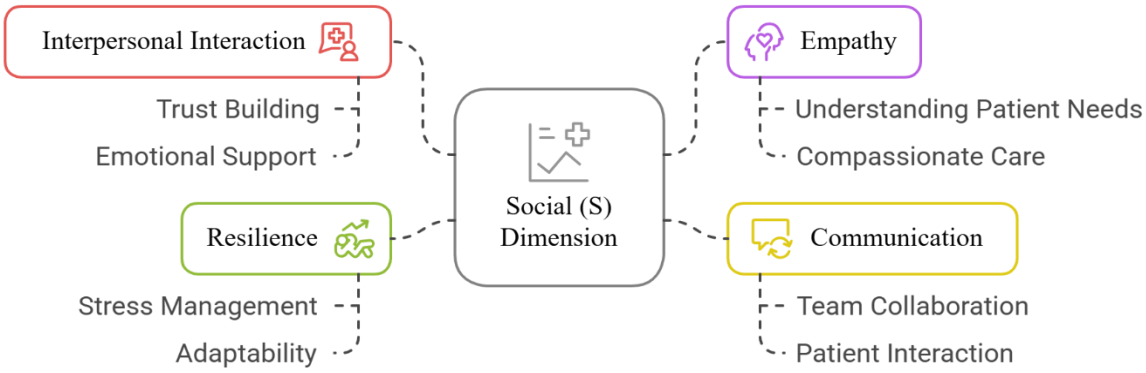

Figure 1. The overall personality traits and healthcare occupations

Alignment between personality and occupational role is also associated with better job satisfaction and psychological well-being. When social tendencies are expressed in roles that require sustained interpersonal work, individuals are more likely to remain engaged and resilient under routine stressors (Dewasiri et al., 2024; Di Fabio & Palazzeschi, 2012). Earlier studies in medical contexts reported that broader personality dispositions, including emotional stability and agreeableness, contribute to thriving in patient centred environments, which complements the present focus on social orientation (Dods & Treppa, 1978; Downing et al., 1964).

Context matters as well. Research on South Korea's medical tourism workforce indicates that personal values shape how staff project brand personality, suggesting that underlying traits influence not only direct interaction but also the perceived character of care organisations (Guiry & Vequist, 2015). Findings from Italian hospital teams highlight that emotional intelligence and perceived fairness support collaboration, which situates social orientation within a wider set of interpersonal capacities that foster healthy work climates (Di Fabio & Palazzeschi, 2012).

Taken together, the high scoring social subgroup identified by the empirical threshold provides a clear and defensible basis for targeted applications. These individuals are strong candidates for patient facing and community roles and they are also likely to benefit from development pathways that deepen communication, empathy, and teamwork. Integrating personality assessment into recruitment and human resource practices can therefore support workforce stability, job satisfaction, and patient outcomes in the healthcare sector (Woods et al., 2016; Duffy et al., 2009).

Creative potential and engagement

Using empirical cut offs set at the top quartile of the observed distribution, 45 of 130 respondents met or exceeded the Artistic threshold of 21, which corresponds to 34.6%. Figure 2 visualises this pattern and situates it alongside exemplar healthcare roles that benefit from creativity. Although the mean Artistic score for the full sample was 16.4, the high scoring subgroup indicates a sizeable pool with stronger imaginative and expressive tendencies. In healthcare and social helping contexts, such tendencies can support therapeutic communication, engaging health education, and community outreach where novel framing and clear storytelling matter (Terry et al., 2019; Kuntarti et al., 2020; Bagley et al., 2018).

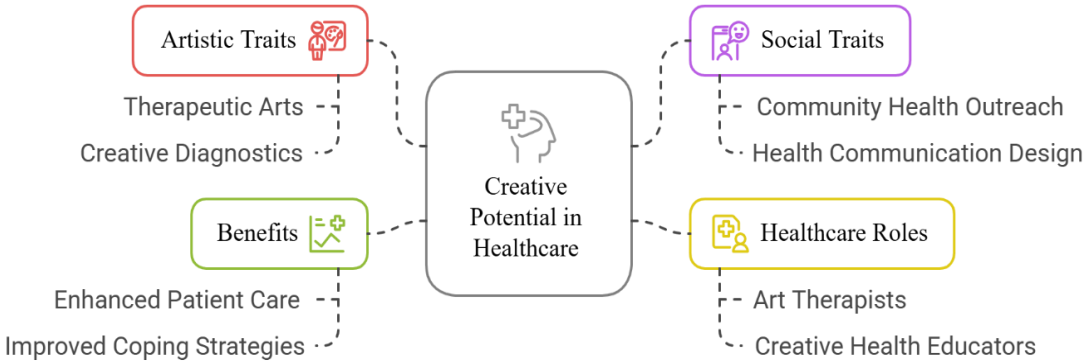

Figure 2. The overall creative potential in healthcare roles

This finding aligns with prior work showing that creative capacity enhances clinical practice when paired with empathy and patient focus. For example, studies report that nursing students and practitioners with stronger artistic and socio emotional profiles are more inclined toward roles that require adaptability and innovation, including rural service and community-based care (Terry et al., 2019). Personality driven empathy and creative communication have been linked to better rapport and service satisfaction in caregiving settings, suggesting that the Artistic profile can translate into tangible care experiences for patients and families (Misron et al., 2025; Kuntarti et al., 2020; Bagley et al., 2018). Classic work on selection and training also points to the contribution of broader personality indicators to clinical judgment and observation, capacities that are often strengthened by openness and imagination (Ferguson et al., 2000; Day & Bedeian, 1995; Jegede, 1981).

The presence of Artistic traits among those who also score highly on Social is particularly valuable. Such individuals are well suited for roles that blend helping with design and expression, including therapeutic arts, creative diagnostics, health communication design, and community engagement initiatives. Creative health educators and wellness practitioners often draw on this profile to craft campaigns and teaching strategies that resonate across diverse populations, improving comprehension and adherence (Borges & Osmon, 2001; Bagley et al., 2018). From a vocational perspective, the coexistence of artistic and social tendencies is consistent with specialty choices that rely on human connection and innovation, such as psychiatry, pediatrics, and public health (Taber et al., 2011; Borges & Savickas, 2002).

Creativity also relates to coping and resilience among healthcare providers. Evidence from nursing staff shows that individuals with well-developed personality frameworks, including creative traits, manage stress more flexibly and sustain adaptive functioning in demanding environments. Encouraging creative thinking can therefore support both patient benefit and staff well-being by expanding the repertoire of problem solving and reflection under pressure (Mariage & Schmitt-Fourrier, 2006). In sum, the high scoring Artistic subgroup identified by empirical thresholds represents a practical talent pool for roles where imagination, empathy, and innovation can improve care processes and patient engagement.

Leadership and structured administration

Using empirical cut offs set at the top quartile of the observed distribution, 38 of 130 respondents met or exceeded the Enterprising threshold of 23, and 55 met or exceeded the Conventional threshold of 31, corresponding to 29.2% and 42.3% respectively. Ties at the cut off account for proportions above 25%. Means for the full sample were 20.4 for Enterprising and 29.6 for Conventional. Figure 3 illustrates these distributions alongside exemplar roles. High Enterprising scores indicate initiative, persuasion, and coordination, while high Conventional scores indicate comfort with structure, documentation, and standards. Together these profiles support administrative and managerial functions in hospitals and social service organisations, including scheduling, compliance, and team supervision (Komari & Djafar, 2023; Salari & Soroushnia, 2015; Aji & Muslichah, 2023).

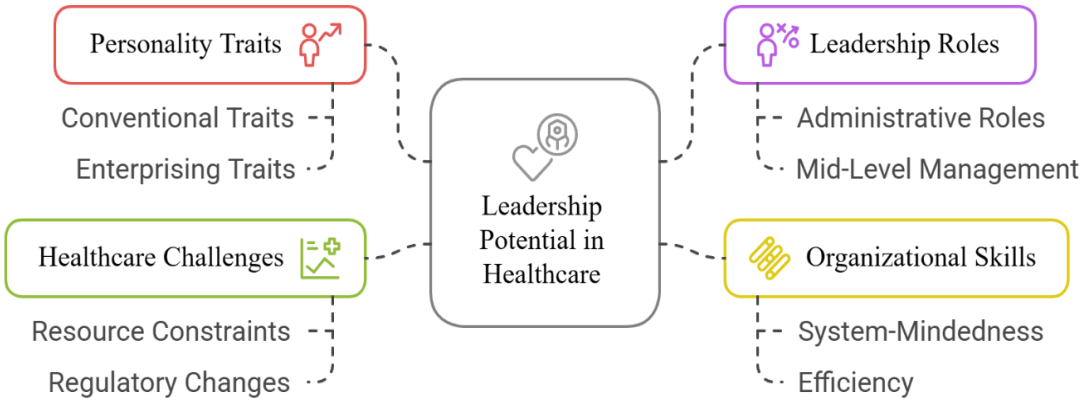

Figure 3. The overall leadership potential in healthcare with the personality traits and its impacts.

Individuals who score highly on both Enterprising and Conventional are strong candidates for roles that combine people management with systems thinking. These roles require strategic planning, decision making, and operational discipline to maintain efficient and empathetic services. In practice, mid-level managers and administrators need self efficacy, assertiveness, and a system minded outlook to coordinate multidisciplinary teams and ensure adherence to protocols (Omazi, 2017; Aji & Muslichah, 2023). Evidence from healthcare settings links personality congruence with structured and leadership tasks to better team functioning and perceived service quality, positioning these traits as useful markers for internal promotion and targeted development (Di Fabio & Palazzeschi, 2012; Schätzle et al., 2024; Komari & Djafar, 2023).

Leadership in healthcare also involves navigating resource constraints, regulatory change, and diverse patient needs. High Conventional scorers tend to support quality assurance, documentation integrity, and process reliability, while high Enterprising scorers drive coordination, persuasion, and change implementation. This complementary pattern is well suited to environments where clarity, structure, and initiative must coexist, including emergency units and governance committees. Earlier work suggests that such profiles are associated with better handling of stressors and organisational strain, both personally and in leading teams through change (Arsenault et al., 1991).

Workforce outcomes follow the same logic. Structured environments shaped by Conventional tendencies can reduce ambiguity and improve communication channels. Enterprising tendencies can energise performance and morale by focusing teams on goals and progress. These dynamics contribute to job satisfaction, lower turnover, and patient centred initiatives when they are supported by fair processes and collaborative climates (Bagley et al., 2018; Di Fabio and Palazzeschi, 2012; Komari and Djafar, 2023). In sum, the empirical high scoring groups for Enterprising and Conventional identified here represent a practical pool for leadership pathways, supervisory assignments, and administrative roles where consistent standards and proactive coordination are both essential.

Limitations of the study

Sampling and generalisability: The data came from a convenience sample of 130 respondents drawn from one organisational source. There was no stratification by age, gender, educational level, or occupation, and nonresponse information was not available. These features limit external validity and make it unclear how well the findings extend to other institutions, regions, or cultures.

Self-report measurement: All variables were self-reported. Responses may be affected by social desirability, acquiescence, or inattentive responding. Although internal consistency was acceptable, we did not assess test–retest reliability. The questionnaire used dichotomous items, which reduce score variance and can introduce ceiling or floor effects. Language and contextual interpretations of items were not independently verified across subgroups.

Construct mapping and overlap: The mapping from FIKR facets to RIASEC dimensions followed conceptual alignment, but some facets appear in more than one domain. For example, elements of Extraversion contribute to both Social and Enterprising scores, which can inflate shared variance and blur distinctions between domains. We did not perform factor analysis, bifactor modelling, or measurement invariance tests to confirm structure across subgroups.

Thresholding and analytic choices: “High” scores were defined by top quartile cut offs within this sample. These are norm referenced rather than criterion referenced and are therefore sample specific. Ties at the cut off raised the proportion above 25% in several dimensions. This improves transparency within the study but complicates comparisons across studies and settings. Analyses were primarily descriptive with planned chi square tests and correlations; we did not correct for multiple comparisons, and the study was not powered for fine grained subgroup analyses.

Design and causal inference: The cross-sectional design captures a single time point. We cannot infer causal relations between traits and role suitability, nor can we observe stability of profiles or movement across roles over time. No intervention or longitudinal follow up was conducted.

Application to outcomes: We did not link profiles to external performance indicators such as supervisor ratings, training outcomes, retention, or patient experience. As a result, claims about practical utility should be viewed as hypotheses that require outcome-based validation before use in high stakes decisions.

Procedural constraints: This was a secondary analysis of anonymised data. We did not control administration conditions, which may vary across respondents and introduce mode effects. Although the study was exempted under institutional guidelines, we did not independently verify all procedural details of data collection.

Conclusion

This study used empirical seventy fifth percentile cut offs to identify subgroups with strong Social, Artistic, Enterprising, and Conventional tendencies relevant to healthcare and social helping work. The approach is transparent and reproducible and provides a practical basis for role placement and targeted development. Social high scorers are candidates for patient facing functions. Artistic high scorers can strengthen creative and educational tasks. Enterprising high scorers can be channelled to leadership and coordination, and Conventional high scorers to structured administrative roles. These applications can support recruitment, retention, and quality improvement in systems that rely on human interaction and organised service delivery.

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Author contributions

Chee Kong Yap: conception and design, analysis, and writing. Chee Seng Leow: validation and review. Wing Sum Vincent Leong: data interpretation and review. All authors contributed to data curation and manuscript editing.

Conflict of interests

The authors declare no conflict of interest.

Ethics approval

This secondary analysis of anonymised data was exempted from full review under institutional guidelines and followed the Declaration of Helsinki.

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