

Review article

## APPLICATION OF THE CONCEPTUAL MODEL OF JEAN WATSON'S *THEORY OF HUMANISTIC CARING* IN PATIENTS AFTER TA-TAVI

Júlia Tájková Csanády<sup>1,2\*</sup>, Vojtěch Kurfirst<sup>1,2</sup>, Lenka Šedová<sup>1</sup>

<sup>1</sup> University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, České Budějovice, Czech Republic

<sup>2</sup> České Budějovice Hospital, Department of Cardiac Surgery, Thoracic Surgery and Vascular Surgery, České Budějovice, Czech Republic

### Abstract

*Introduction:* Jean Watson's theory of humanistic care is a humanistic-existential framework for nursing based on relationality, empathy, and spiritual presence. In the highly technical environment of cardiac surgery, such as TA-TAVI, it enables a human and holistic approach to the patient.

*Goal:* To systematically evaluate the available evidence on the application of the Watson model in nursing care for patients after transapical transcatheter aortic valve implantation (TA-TAVI).

*Methods:* A systematic review study in accordance with the PRISMA 2020 recommendations and the PICO(S) methodological framework. Searches in PubMed, Scopus, CINAHL, Web of Science, and Google Scholar databases (2000–2025). After removing duplicates and irrelevant records, 20 studies were included in the qualitative synthesis.

*Results:* The identified studies demonstrate the benefits of the Watson model for improving nurse-patient communication and relationships, promoting psychospiritual well-being, reducing stress and anxiety, strengthening professional identity, and treatment adherence. Barriers to implementation include limited time, personnel capacity, and institutional support.

*Conclusion:* The Watson model has significant potential to improve nursing care after TA-TAVI. Its implementation requires structural support, education, and cultural change towards value-based practice.

**Keywords:** *Caritas; Communication; Jean Watson; Jean Watson's Theory of Human Care; Nursing Model; Spirituality; TA-TAVI*

## INTRODUCTION

Aortic stenosis is the most common acquired valvular disease in adults. Its prevalence increases with age, contributing significantly to morbidity and mortality in the geriatric population (Lindman et al., 2016). In patients with high surgical risk for whom the transfemoral route is not appropriate, transapical transcatheter aortic valve implantation (TA-TAVI) represents an essential alternative to surgical valve replacement (Eltchaninoff et al., 2011). It is a technically demanding procedure that is

indicated especially in patients who are polymorbid, geriatrically frail, and psychosocially vulnerable. Nursing care in the perioperative period of TA-TAVI, therefore, requires not only advanced professional knowledge, but also the ability to perceive the complex needs of the patient in bio-psycho-social-spiritual contexts.

Jean Watson's theory of human care is a theoretical framework that integrates these requirements. Its philosophical foundations lie in humanism, holism, and phenomenology (Scholz and Tóthová, 2010). Humanism

emphasises respect for the dignity and values of each person, holism understands the patient as a unity of body, mind and spirit, and phenomenology is based on the principle of “epoché”, i.e., the conscious suspension of judgment so that the patient can be perceived without prejudice (Carman, 2007; Watson, 1999). The model was formulated initially through ten “Carative Factors”, which Watson later reformulated into “Caritas Processes” with an emphasis on the spiritual and existential dimension of care (Buber, 1970; Cara, 2003; Fawcett, 2002; Rogers, 1995; Sitzman and Watson, 2018). It is ideologically based on the humanistic-existential philosophy and the self-actualisation theory of Abraham Maslow.

Abroad, Watson’s theory has been successfully applied in acute and intensive care, including cardiology and cardiac surgery, but in the Czech environment, its implementation is limited and often unsystematic. Previous work is primarily limited to narrative descrip-

tions of experiences, but a synthetic view of evidence from clinical practice is missing, especially in patients after TA-TAVI. This systematic review aims to evaluate the available evidence on the benefits, barriers, and feasibility of implementing Jean Watson’s conceptual model in nursing care for patients after TA-TAVI.

## MATERIALS AND METHODS

This article was prepared as a systematic review study in accordance with the PRISMA 2020 recommendations and using the PICO(S) methodological framework (Population, Intervention, Comparison, Outcome, Study design). The methodological part aims to ensure a transparent, reproducible, and scientifically valid process for identifying, selecting, and analysing published evidence on the application of the Jean Watson model in clinical nursing practice (Table 1).

**Table 1 – Formulation of the research question according to PICO(S)**

Component	Definitions for this study
P (Population)	Patients after transapical transcatheter aortic valve implantation (TA-TAVI) and healthcare professionals (especially nurses) providing care to these patients
I (Intervention)	Application of Jean Watson’s conceptual model (Caritas Processes) in clinical nursing practice
C (Comparison)	Standard nursing care without explicit application of the Watson model (if reported in studies)
O (Outcomes)	Quality of nursing care, level of communication, psychospiritual well-being of patients, adherence to treatment, nurse satisfaction, and prevention of burnout
S (Study design)	Qualitative, quantitative, mixed studies and systematic reviews published between 2000 and 2025

### Research question:

*What are the benefits, barriers, and opportunities for implementing the Jean Watson conceptual model in nursing care of patients after TA-TAVI compared to standard care?*

### Research strategies

The search was conducted in the databases PubMed, Scopus, Web of Science, CINAHL, ScienceDirect, and Google Scholar between January and April 2025.

We used the combination of keywords and their synonyms:

“Jean Watson”, “Watson’s caring theory”, “caritas processes”, “TA-TAVI”, “transapical transcatheter aortic valve implantation”, “nursing care”, “holistic care”, “caring science”. Boolean operators AND and OR allowed for combining terms and refining queries. Results were exported to a spreadsheet and analysed by relevance, year of publication, language, and full-text availability.

### Inclusion criteria:

- Qualitative, quantitative, mixed studies and systematic reviews.

- Population: patients after TA-TAVI or similar procedure, nurses providing nursing care to these patients.
- Explicit application of the Watson model or Caritas Processes.
- Publications from 2000–2025, in English or Czech, with full text available.

#### Exclusion criteria:

- Studies without clinical context (theoretical essays, philosophical commentaries without empirical data).
- Unverified or non-peer-reviewed sources.
- Duplicates and publications older than 25 years, unless they directly contribute to the theory of Watson's model.

### Study selection process (PRISMA 2020)

In the first phase, 490 records were identified (PubMed = 125; Scopus = 98; CINAHL = 85; Web of Science = 72; Google Scholar = 110).

After removing 148 duplicates, 342 records remained. After screening titles and abstracts, 266 records were discarded as irrelevant.

76 studies were included in the full-text analysis, of which 48 were excluded after detailed assessment.

The final set consisted of 32 studies, of which 20 were included in the qualitative synthesis (Table 2).

The process of identifying, selecting, and including studies is illustrated in the PRISMA 2020 Flowchart (Diagram 1).

### Data extraction and analysis

The following data were extracted from each study: author, year of publication, study type, population, context, objectives, primary findings, and implications for practice.

The data were analysed using thematic analysis, following Braun and Clark (2006). Four thematic domains were identified:

1. Communication and relationships
2. The patient's psychospiritual well-being
3. Professional identity and resilience of healthcare professionals
4. Quality and continuity of care

The validity of the analysis was ensured through double reading, triangulation of sources, and consistency checks of the con-

clusions. A systematic review according to PICO(S) and visualisation of the selection process using PRISMA were used to present the results.

### Note on methodology

The PICO(S) framework was used to formulate the research question and systematise the analysis. In contrast, PRISMA 2020 was used solely to transparently illustrate the search and selection process for studies (not as a quality assessment method).

The combination of both approaches ensures both theoretical consistency and transparency of the research process. The process of identifying and selecting studies is illustrated in Diagram 1.

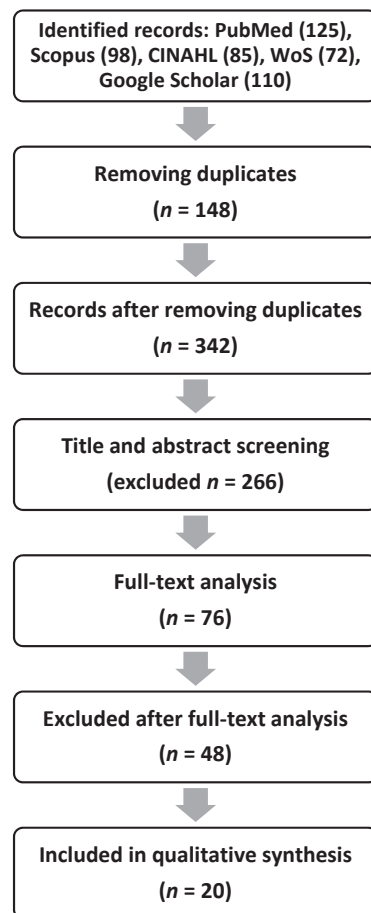


Diagram 1 – PRISMA flowchart

## RESULTS

An analysis of 20 selected studies showed consistent evidence of a positive effect of the Watson model on clinical and psychological aspects of care after TA-TAVI. Improvements were noted in communication, patients' emotional stability, and healthcare professionals'

satisfaction. Time and personnel limitations, as well as insufficient institutional support, remain barriers. The findings are in line with current clinical recommendations for the care of patients with valvular disease, which emphasise an interdisciplinary, patient-centred approach (Bleiziffer et al., 2020; Dvir and Webb, 2015; Otto et al., 2021) – Table 2.

**Table 2 – Overview of selected studies (n = 20)**

Author (year)	Type of research	Population/ Context	Results	Main findings
Scholz and Tóthová, 2010	Overview/case study	Patients with DM1	Practical operationalisation of the 10 factors of care	Strengthening empathy, education, and holism
Brilowski and Wendler, 2005	Conceptual analysis	Caring theory	Evolutionary analysis of the concept	Caring as the foundation of nursing
Watson, 2008	Monograph	Caring science	Philosophy and science of care	Implementation of Caritas processes
Nelson et al., 2011	International research	Caritas evaluation	Caring tools and metrics	Care impact assessment
Sitzman and Watson, 2018	Monograph	Clinic, education	Implementation of Caritas in practice	Higher level of satisfaction, lower level of burnout
Ray and Turkel, 2015	Theoretical research	Relational caring praxis	Complexity of relationship care	Caring as an emancipatory practice
González-Cebrian et al., 2022	Quantitative	Patients before TAVI	Nursing-guided preparation	Better adherence, less stress
Otto et al., 2021	Guidelines	VHD/TAVI	ACC/AHA recommendations	Framework for comprehensive care
Ray and Turkel, 2014	Theoretical and conceptual work	Caring processes in organisational and systemic contexts	Shows how caring processes are connected to organisational structures, ethics, and complex care systems	Caring is a dynamic and relational process that transforms organisational and clinical culture and strengthens ethical and humanistic practice
Braun and Clarke, 2006	Methodological work, Qualitative research	Thematic analysis as a systematic method of data interpretation	Defining and systematising thematic analysis: a six-step process for organising and interpreting qualitative data	Thematic analysis provides a flexible, replicable framework for deep interpretation of experiences and caring processes
Pajnikihar et al., 2017	Analysis/Evaluation	Watson's theory	Theoretical evaluation of the model	Strengths and weaknesses of the concept
Turkel et al., 2018	Essay/Overview	Caring science	Re-framing the science of care	Supporting a caring culture
Nelson and Watson, 2011	Monograph	International research	A set of empirical studies	Caritas measurability and clinical impact
Eriksson, 2007	Theoretical/Philosophical	Spiritual care	Concept of suffering and caring	Connecting care and spirituality
Fawcett, 2002	Overview analysis	Nursing theories	Updating the 21st century theories	Watson model validation
Archalousová and Slezáková, 2005	Case study/Practice	Czech clinical practice	Application of models in nursing	Transferability of the Watson model to the Czech environment

Based on a thematic analysis of selected studies (Braun and Clarke, 2006), four primary areas of benefit from applying the Jean Watson model in clinical practice, particularly in the context of patient care after TA-TAVI, were identified:

### *1. Improving communication and establishing relationships*

The implementation of Caritas principles leads to a change in the paradigm of communication – from routine information exchange to deeply human and empathetic dialogue (Watson, 2008). In clinical practice, this means a transition from a transactional to a transformational model, based on active listening, presence, and respect. This approach includes, for example, maintaining eye contact, using a calm voice, validating emotions, and practising conscious patience. For patients after TA-TAVI, who often experience anxiety, loneliness, and existential uncertainty, high-quality communication is of fundamental therapeutic importance. Creating a safe communication space strengthens trust, reduces psychophysiological stress, and increases treatment adherence. Patients who experience the relational presence of healthcare professionals are more likely to express confidence in the healing process and actively participate in recovery (Turkel et al., 2018).

### *2. Supporting the patient's psychospiritual well-being*

Presence, touch, and the ability to create a safe space reduce the stress response, stabilise physiological parameters, and positively influence the patient's emotional state (Eriksson, 2002; Nelson and Watson, 2011). For patients after TA-TAVI, who often face uncertainty and fear of complications, the spiritual dimension of care becomes particularly important. Watson describes these moments as a space for a transpersonal healing relationship, where two beings meet in truth and compassion. In practice, this includes conscious silence, ritual accompaniment, or empathic presence. Studies have shown reductions in hospital stay length, a lower need for sedatives, and higher satisfaction with care (Turkel et al., 2018).

### *3. Professional growth and mental health of healthcare professionals*

The application of the Watson model strengthens professional identity and the meaningful-

ness of work. Caritas processes guide healthcare professionals to conscious presence, thereby reducing the risk of burnout and promoting resilience (Sitzman and Watson, 2018). Research from the intensive care environment confirms improvements in teamwork and the overall workplace atmosphere (Liao et al., 2023; Ray and Turkel, 2014). Healthcare professionals reflect on their emotions, engage in ethical dialogue, and practice self-reflection, which are key to the long-term sustainability of professional performance in the demanding TA-TAVI environment.

### *4. Increasing the quality and continuity of care*

The application of Watson's philosophy promotes active patient engagement, improves team communication, and strengthens trust between patients and healthcare professionals (Nelson and Watson, 2011). This approach supports patient autonomy and continuity of care. Healthcare professionals have reported improved teamwork and professional satisfaction when implementing value-based approaches (Sitzman and Watson, 2018). These results have also been confirmed by recent European recommendations (Leon et al., 2016; Vahanian et al., 2022).

Overall, Watson's model helps bridge the gap between the technological sophistication of a procedure such as TA-TAVI and the complex needs of the patient, which include not only biological stabilisation but also psychological balance and spiritual anchoring.

## **DISCUSSION**

The findings of this review study confirm that Jean Watson's model represents an important and highly relevant approach to contemporary nursing, which is of fundamental importance not only in the theoretical framework but also in everyday clinical practice. Watson's concept restores care to its original ethical and spiritual dimension. This is highly relevant in today's healthcare system, burdened by technology and performance orientation. The application of her model brings measurable benefits in terms of the quality of care, patients' emotional well-being, healthcare professionals' professional satisfaction, and overall system effectiveness (Brilowski and

Wendler, 2005; Sitzman and Watson, 2018; Watson, 2008).

In the context of TA-TAVI, a highly technical procedure designed for polymorbid, geriatrically frail, and psychosocially vulnerable patients, Jean Watson's model takes on extraordinary significance. These patients often present with fear, loneliness, uncertainty about prognosis, and dependence on others. Thus, technical mastery of the procedure represents only one dimension of care; creating a safe space where the patient is perceived as a whole human being is equally important. Here, Watson's approach becomes a key tool, providing a framework in which care becomes a relationship rather than just an intervention.

One of the most significant benefits of the Watson model is its ability to restore the human dimension of care in environments that are often overloaded, performance-oriented, and lack space for relational presence. It is in the cardiac surgery and intensive care settings that active listening, nonverbal communication, conscious presence, and the ability to create a trusting relationship have been shown to significantly influence not only the patient's subjective experience, but also their clinical outcomes (Ray and Turkel, 2014; Turkel et al., 2018). Patients with limited verbal ability or cognitive deficits, in particular, benefit from gentle, non-verbal care, which becomes a channel for recognition and respect.

At the same time, the literature shows that implementing the Jean Watson model is not easy. It is not a technique, but a change in thinking and culture. It requires deep personal reflection, the willingness of healthcare professionals to change established routines, the ability of management to create a safe environment for self-development, and structural support. Many institutions lack the time, space, and management willing to invest in cultivating the value dimension of care. Nevertheless, even partial implementation of selected Caritas Processes, such as compassionate intervention, active listening, or ritual accompaniment, can lead to a significant change in the workplace atmosphere and to an improvement in the patient experience.

Experience from abroad shows that introducing the Watson model into clinical practice is feasible and beneficial. In some hospitals in the USA and Scandinavia, so-called

Caritas Teams or Caring Science Units have been introduced, which systematically support the culture of care, organise ethical case studies, workshops, supervision, and facilitate reflection. In the United States, the Watson model is part of hospital standards and is one of the tools for sustaining nurses' professional identity (Liao et al., 2023; Nelson and Watson, 2011; Nelson et al., 2011; Ray and Turkel, 2015).

An essential tool for the sustainability of this approach is the development of so-called reflective practice; that is, conscious and structured work with oneself, with experiences and emotions from clinical care. This practice can be implemented in the form of individual self-reflection, team supervisions, case seminars, or support groups. Watson points out that caring for others requires being consciously present and, at the same time, cultivating self-care. This level of care is often neglected, yet it is key to preventing burnout and maintaining authenticity of care (Nelson and Watson, 2011; Turkel et al., 2018).

In the Czech environment, the main challenges are the shortage of personnel, the time-pressured nature of clinical practice, the high administrative burden, and insufficient institutional recognition of the importance of nursing values. Healthcare professionals often fill multiple roles, lack space for self-reflection, and operate under long-term performance pressure. According to Watson, the introduction of a value-oriented approach would require not only changes in individuals' approaches, but also systemic support from management, schools, and professional organisations. Ethical reflection, support for professional identity, and the possibility of supervision and access to education should be integral to professional development.

Watson's model does not function as a universal prescription, but as a framework for transforming nursing towards a deeper, more relational, and ethically rooted concept of care. In the context of TA-TAVI, its contribution is obvious; it offers a means to bridge the gap between the technological sophistication of the performance and the existential fragility of the patient. Implementing this approach has the potential to change not only the relationship between the patient and the nurse but also the atmosphere of the entire healthcare facility.

Overall, the Watson model helps bridge the gap between the technological sophistication of a procedure such as TA-TAVI and the complex needs of the patient, which include not only biological stabilisation but also psychological balance, emotional support, and spiritual anchoring. The high level of invasiveness, the risk of the procedure, and the presence of polymorbidities make patients after TA-TAVI a particularly vulnerable group for whom human contact, presence, and trust are essential therapeutic elements (Leon et al., 2016; Vahanian et al., 2022). The application of the Watson model supports a holistic view of the patient, where each patient is understood as a unique being with a personal history, values, and experience of the disease. The individualised approach in the spirit of the Caritas Processes thus allows for tailoring care not only to the clinical condition but also to the patient's mental, social, and spiritual needs, reflected in better adherence, higher satisfaction, and better quality of recovery.

In the Czech context, only a limited number of authors have addressed the implementation of the Jean Watson model (Archalousová and Slezáková, 2005; Scholz and Tóthová, 2010). The main barriers remain the lack of personnel, administrative burden, and limited institutional support. This situation leads to the routinisation of care and a loss of contact with the original mission of nursing (Fajkus, 2005; Farkašová et al., 2006; Pavlíková, 2006; Trachtová et al., 2008). Nevertheless, the Watson model offers practical tools for the renewal of professional identity, ethical reflection, and a humanistic approach to care.

Watson's model does not function as a universal technique but as a philosophical-practical framework for transforming nursing culture. In the context of TA-TAVI, its contribution is obvious; it bridges the gap between the technological precision of performance and the existential vulnerability of the patient.

The Jean Watson model of nursing care represents a comprehensive, deeply humanistic, and spiritually grounded approach that significantly enriches the current nursing paradigm. Its strength lies in its emphasis on humanity, trust, relational presence, and ethically grounded action in technologically oriented practice.

In the context of TA-TAVI patient care, this approach is particularly beneficial. These patients are often geriatrically frail, weakened by comorbidities, and emotionally vulnerable. They undergo a highly invasive procedure in a situation of increased fear, uncertainty, and dependence on others. It is here that the transformative potential of the Watson model is demonstrated; it enables healthcare professionals to provide care that is not only technically correct, but also kind, dignified, and healing. This is care that does not isolate a person in the shadow of a diagnosis but accepts them as a whole being.

The model allows healthcare professionals not only to “do”, but above all to “be” – to be present, to listen, to accompany, and to perceive the patient as a whole being, not just as an object of treatment. Implementing the Watson model brings measurable benefits: it improves the quality of the relationship between the nurse and the patient, reduces the psychological burden of healthcare professionals, supports teamwork, and contributes to higher professional satisfaction. However, implementing this model requires a long-term strategy; education, supervision, organisational changes, management support, and, above all, the willingness of healthcare professionals to cultivate their approach to everyday care. The model does not serve to replace professional knowledge, but to supplement it with a dimension that is irreplaceable in human care – the dimension of humanity, compassion, and deep relationships (Watson, 2008).

However, in the Czech environment, Watson's model is still not sufficiently implemented. Nursing as an independent scientific discipline still faces insufficient recognition and limited autonomy in the Czech Republic, which complicates the implementation of complex conceptual frameworks into practice (Scholz and Tóthová, 2010). Nurses face excessive workloads, often substitute multiple functions simultaneously, and lack the space for deeper relational care and reflection. This situation leads to professional frustration, routines in care, and loss of contact with the original mission of the helping profession (Archalousová and Slezáková, 2005; Farkašová et al., 2006).

Nevertheless, Watson's model has considerable potential in the Czech environment. Its philosophical foundations – humanism, phe-

nomenclology, holism – provide nurses with the tools to care not only for physical needs but also for the psychological, social, and spiritual dimensions of health. As Scholz and Tóthová (2010) state, this model supports empathy and relational presence even under high performance pressure and legislative burden, thereby helping to bridge the gap between the “duty” and the “mission” of nursing.

For these reasons, there is room to strengthen interdisciplinary discussion on the importance of values in care, to develop educational modules focused on caring science, to support the establishment of Caritas teams, and to integrate Caritas Processes into everyday nursing practice. It is also necessary to create stable institutional support – both from universities and from healthcare facility management – that will allow healthcare professionals to cultivate a deeper, more humane way of caring safely (Scholz and Tóthová; Watson, 2008).

Both healthcare professionals’ statements and research findings suggest that the cold or distant communication style in Czech hospital culture is not the result of a lack of empathy, but rather a defensive reaction to long-term overload and a lack of tools for self-reflection and emotional processing of challenging situations. It is in this context that Watson’s model may have fundamental transformative potential, offering not only a language for articulating the values of care, but also specific tools and procedures for putting these values into practice. It helps healthcare professionals rediscover the meaning of their work, restore their professional identity, and ultimately cultivate an environment in which care is once again perceived as a human, relational, and value-based process – not just a technical performance.

Based on these findings, we recommend strengthening interdisciplinary discussion of the importance of values in care, developing educational modules focused on caring science, supporting the establishment of Caritas teams, and implementing Caritas Processes into everyday nursing practice. At the same time, it is necessary to take into account the local context, the needs of healthcare professionals, and organisational realities. Watson’s model does not offer instant solutions, but is a path that requires patience, effort, and openness.

## Limitations

This review has several methodological limitations. Although a transparent strategy following the PRISMA framework and the PICO(S) methodological model was used, the results may be influenced by the heterogeneity of the included studies, varying data quality, and different research designs. The predominance of qualitative studies may reduce the possibility of generalising the results quantitatively. Another limitation is the language selection – it only works in English, and Czech was included in the review, which may have led to the omission of relevant sources in other languages. Therefore, the conclusions should be interpreted in the context of the available evidence and serve as a basis for further empirical research on the application of the Watson model across different clinical settings.

## CONCLUSION

Watson’s model is not just a theory but a call for ethically anchored, relational, and deeply human nursing. Its application in the context of TA-TAVI confirms that even in a technologically demanding environment, care can be provided that is not only professionally competent but also truly healing. Such care leads to a return to nursing’s original mission: to be close to the person in their vulnerability and hope.

Jean Watson’s model brings a new dimension to the care of patients after TA-TAVI, combining professional competence with spiritual presence, empathy, and respect.

Its implementation can improve not only the quality of nursing care and patient experience, but also nurses’ well-being at work and professional identity.

For successful implementation, it is necessary to create institutional support, develop education in caring science, and promote a reflective culture of care.

Watson’s model thus confirms that, even in a highly technological medical environment, care can be humane, ethical, and truly healing.

## Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

## REFERENCES

1. Archalousová A, Slezáková Z (2005). Aplikace vybraných ošetrovatelských modelů do klinické a komunitní praxe. Nucleus HK, 107 p.
2. Bleiziffer S, Simonato M, Webb JG, Rodes-Cabau J, Pibarot P, Kornowski R, et al. (2020). Long-term outcomes after transcatheter aortic valve implantation in failed bioprosthetic valves. *Eur Heart J* 41(29): 2731–2742. DOI: 10.1093/eurheartj/ehaa093.
3. Braun V, Clarke V (2006). Using thematic analysis in psychology. *Qual Res Psychol* 3(2): 77–101. DOI: 10.1191/1478088706qp0630a.
4. Brilowski GA, Wendler MC (2005). An evolutionary concept analysis of caring. *J Adv Nurs* 50(6): 641–650. DOI: 10.1111/j.1365-2648.2005.03449.x.
5. Buber M (1970). *I and Thou* (W. Kaufmann, Trans.) New York: Charles Scribner's Sons (Original work published in 1923), 120 p.
6. Cara C (2003). A pragmatic view of Jean Watson's caring theory. *Int J Hum Caring* 7(3): 51–61. DOI: 10.20467/1091-5710.7.3.51.
7. Carman T (2007). Husserl and Heidegger. In: Bunning J, Tsui-James E. *The Blackwell Companion to Philosophy*, Wiley-Blackwell, pp. 842–859. DOI: 10.1002/9780470996362.ch43.
8. Dvir D, Webb JG (2015). Transcatheter aortic valve-in-valve implantation for patients with degenerative surgical bioprosthetic valves. *Circ J* 79(4): 695–703. DOI: 10.1253/circj.CJ-14-1418.
9. Eltchaninoff H, Prat A, Gilard M, Leguerrier A, Blanchard D, et al. (2011). Transcatheter aortic valve implantation: early results of the FRANCE (FRench Aortic National CoreValve and Edwards) registry. *Eur Heart J* 32(2): 191–197. DOI: 10.1093/eurheartj/ehq261.
10. Eriksson K (2002). Caring science in a new key. *Nurs Sci Q* 15(1): 61–65. DOI: 10.1177/089431840201500110.
11. Fajkus B (2005). *Filosofie a metodologie vědy*. Praha: Academia, 368 p.
12. Farkašová D, et al. (2006). *Ošetrovatelství – teorie*. Martin: Osveta, 212 p.
13. Fawcett J (2002). The nurse theorists: 21st-century updates – Jean Watson. *Nurs Sci Q* 15(3): 214–219. DOI: 10.1177/08918402015003007.
14. González-Cebrian M, Alonso-Fernández-Gatta M, Sánchez RC, González Egado EO, Meléndez SA, Ferrín Prieto C, et al. (2022). Nursing-Guided Pre-Procedural Preparation In Patients Undergoing Transcatheter Aortic Valve Replacement. *Int J Nurs Health Care Res* 5: 1354. DOI: 10.29011/2688-9501.101354.
15. Leon MB, Smith CR, Mack MJ, Makkar RR, Svensson LG, Kodali SK, et al. (2016). Transcatheter or surgical aortic-valve replacement in intermediate-risk patients. *N Engl J Med* 374(17): 1609–1620. DOI: 10.1056/NEJMoa1514616.
16. Liao L, Zhang F, Zhang Y, Guan C, Xu G, Yuan C, et al. (2023). Nurse managers' perceptions and experiences of caring behavior for clinical nurses: a multicenter survey. *BMC Nurs* 22(1): 383. DOI: 10.1186/s12912-023-01541-0.
17. Lindman BR, Clavel MA, Mathieu P, Iung B, Lancellotti P, Otto CM, Pibarot P (2016). Calcific aortic stenosis. *Nat Rev Dis Primers* 2: 16006. DOI: 10.1038/nrdp.2016.6.
18. Nelson J, Watson J (Eds) (2011). *Measuring caring: International research on caritas as healing*. Springer Publishing Company, 450 p.
19. Nelson J, Itzhaki M, Ehrenfeld M, Tinker A, Hozak MA, Johnson S (2011). *Nurses' Caring for Self: A Four-Country Descriptive Study (England, Israel, New Zealand, and the United States)*. *Measuring Caring: International Research on Caritas as Healing*, pp. 357–370.
20. Otto CM, Nishimura RA, Bonow RO, Carabello BA, Erwin JP, 3rd., Gentile F, et al. (2021). 2020 ACC/AHA Guideline for the management of patients with valvular heart disease. *Circulation* 143(5): e35–e71. DOI: 10.1161/CIR.0000000000000932.
21. Pajnkihar M, McKenna HP, Štiglic G, Vrbnjak D (2017). Fit for practice: analysis and evaluation of Watson's theory of human caring. *Nurs Sci Q* 30(3): 243–252. DOI: 10.1177/0894318417708409.
22. Pavlíková S (2006). *Modely ošetrovatelství v kostce*. Praha: Grada, 150 p.
23. Ray MA, Turkel MC (2014). Caring as emancipatory nursing praxis: The theory of relational caring complexity. *ANS Adv Nurs Sci* 37(2): 132–146. DOI: 10.1097/ANS.000000000000024.

24. Ray MA, Turkel MC (2015). Response to Critique of “Caring as Emancipatory Nursing Praxis: The Theory of Relational Caring Complexity”. *ANS Adv Nurs Sci* 38(3): 160–161. DOI: 10.1097/ANS.000000000000085.
25. Rogers C (1995). *A Way of Being*. Boston: Houghton Mifflin, 416 p.
26. Scholz P, Tóthová V (2010). Humanistická péče dle modelu Margaret Jean Watsonové. *Kontakt* 12(1): 34–38. DOI: 10.32725/kont.2010.004.
27. Sitzman K, Watson J (2018). *Caring science, mindful practice: Implementing Watson’s human caring theory*. Springer Publishing Company, 222 p.
28. Trachtová E, et al. (2008). *Potřeby nemocného v ošetrovatelském procesu*. Národní centrum ošetrovatelství a nelékařských zdravotnických oborů, 185 p.
29. Turkel MC, Watson J, Giovannoni J (2018). Caring science or science of caring. *Nurs Sci Q* 31(1): 66–71. DOI: 10.1177/0894318417741116.
30. Vahanian A, Beyersdorf F, Praz F, Milojevic M, Baldus S, Bauersachs J, et al. (2022). 2021 ESC/EACTS Guidelines for the management of valvular heart disease: Developed by the Task Force for the management of valvular heart disease of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). *Eur Heart J* 43(7): 561–632. DOI: 10.1093/eurheartj/ehab395.
31. Watson J (1999). *Postmodern nursing and beyond*. New York: Churchill Livingstone, 256 p.
32. Watson J (2008). *Nursing: The philosophy and science of caring* (Rev. ed.). University Press of Colorado, 336 p.

---

\* **Corresponding author:** Júlia Tájková Csanády, České Budějovice Hospital, Department of Cardiac Surgery, Thoracic Surgery and Vascular Surgery, B. Němcové 585/54, 370 01 České Budějovice, Czech Republic; e-mail: tajkova.julia@nemcb.cz  
<http://doi.org/10.32725/jnss.2026.002>

Submitted: 2025-07-14 • Accepted: 2026-01-30 • Prepublished online: 2026-01-30  
J Nurs Soc Stud Public Health Rehabil 17/1–2: 64–73 • EISSN 1804-7181 • ISSN 1804-1868  
© 2026 The Authors. Published by University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, Czech Republic and International Society of Applied Preventive Medicine, Vienna, Austria  
This is an open access article under the CC BY 4.0 license.