

Guidelines, Policies and Statements

ASUM Guidelines on the Performance of a Gynaecological Ultrasound Examination

Approved by the ASUM Board of Directors, October 2026

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1 Introduction

The Australasian Society for Ultrasound in Medicine (ASUM) is a multidisciplinary society dedicated to enhancing patient outcomes through the safe, effective and high-quality use of ultrasound. ASUM provides leadership in education and the development of professional standards to support excellence in diagnostic and clinical ultrasound practice across Australia and New Zealand, underpinned by evidence-based practice and academic integrity.

These guidelines provide a framework for the performance of gynaecological ultrasound examinations and support consistent, high-quality, patient-centred ultrasound practice.

These guidelines are intended to align with current Australian, New Zealand and international professional standards, accreditation requirements, infection prevention standards, privacy legislation, and professional conduct frameworks relevant to gynaecological ultrasound practice. Practitioners and services are responsible for ensuring compliance with jurisdiction-specific legislative and regulatory requirements.

1.1 Background

Ultrasound is a key component of the investigation of gynaecological pathologies and the status of the pelvic organs. A gynaecological ultrasound examination may be performed via transabdominal, transvaginal or translabial/transperineal approaches. Transvaginal ultrasound is considered the optimal modality for detailed imaging of the pelvic organs. However, the clinical indication for the examination will guide the most appropriate imaging approach. In most circumstances, a standalone transvaginal ultrasound examination will be adequate for most examinations, however any or all three approaches may be utilised in combination.

Clinicians should use appropriate sensitivity and respect for patients when conducting procedures and in addressing any concerns, including cultural and religious factors. It is expected that the ultrasound practitioner conducting the gynaecological scan will demonstrate competence in the use of the equipment and its functions, consistently optimise images, display a systematic approach, demonstrate appropriate interpretation of findings within their scope of practice, and document the relevant images and reporting.

Each healthcare facility must develop a protocol for performing gynaecological ultrasound examinations, relevant to their specific patient cohort.

1.2 Scope

These guidelines are applicable to all ultrasound practitioners working within their scope of practice and applicable regulatory and clinical governance requirements.

2 Abbreviations

Term	Definition
DIAS	Diagnostic Imaging Accreditation Scheme

LMP	Last Menstrual Period
IDEA	International Deep Endometriosis Analysis
IOTA	International Ovarian Tumour Analysis
POD	Pouch of Douglas
TA	Transabdominal
TV	Transvaginal
TVUS	Transvaginal ultrasound

3 Pre-Performance of Ultrasound

3.1 History

An appreciation of the clinical history is important in reaching a diagnosis. Necessary clinical details should be collected by the ultrasound practitioner performing the examination including, but not limited to:

- The presenting symptoms, including characteristics of pain where relevant
- Age of the patient
- Parity
- Menstrual history and LMP
- Relevant fertility history
- Previous gynaecological surgery
- Relevant previous imaging findings
- Current hormonal treatment (e.g. contraceptives, hormone replacement therapy)
- Relevant risk factors for gynaecological malignancy
- Latex allergies

Clinical history should be documented.

3.2 Informed Consent

When performing a gynaecological ultrasound, by any approach, local requirements or organisational policy relating to consent should be adhered to. ^[1] Ultrasound practitioners must familiarise themselves with relevant country/state/territory legislation regarding capacity to consent. (See Appendix A for additional information)

Transvaginal or translabial/transperineal ultrasound is an intimate procedure but considered a low-risk medical procedure for consent purposes. Accordingly, Advisory Statement DI21/05 - Clarification of consent requirements ^[2] for transvaginal ultrasound procedures requires:

- Verbal informed consent is sufficient for low-risk transvaginal ultrasound procedures unless there is a local organisational requirement for written consent.
- Written consent must be obtained for all high-risk procedures, such as those which use transvaginal ultrasound for imaging guidance (e.g. for biopsies) or are otherwise determined by the practice to be high risk for the individual patient.

Consent should be regarded as an ongoing process throughout an intimate examination. The patient may decline or withdraw consent at any time, in which case the examination should cease.

Immediately prior to transducer insertion, the ultrasound practitioner should reconfirm the patient's consent and readiness to proceed.

For additional guidance on consent, chaperones and patient-centred care during transvaginal ultrasound examinations, please refer to the **ASUM Transvaginal Ultrasound Policy (2026)**.

3.3 Patient Preparation

A transabdominal gynaecological ultrasound is typically performed with a full urinary bladder, which acts as an acoustic window to improve visualisation of the pelvic organs and displace adjacent bowel gas.

Transvaginal ultrasound is best performed with an empty bladder to optimise patient comfort and visualisation of the pelvic organs. The patient should be instructed to empty their bladder immediately prior to the examination.

The sequence of the transabdominal and transvaginal ultrasound may vary depending on the clinical indication, patient factors and local practice. In many settings, a transabdominal examination may be performed first, followed by transvaginal ultrasound after bladder emptying.

The timing of the examination within the menstrual cycle may be relevant for some clinical indications.

4 Equipment

4.1 Check Quality of Equipment

- Gynaecological ultrasound (by all approaches) requires the use of high-quality transducers. The highest possible frequency should be utilised to image the desired structure.
- The availability of colour Doppler, power Doppler and spectral Doppler is essential.
- Where available and clinically indicated, three-dimensional (3D) transducers may provide additional diagnostic value.

4.2 Infection Prevention and Control

For transvaginal, translabial and transperineal examinations, transducer covers must be used. These must be latex-free in situations where the patient has a latex allergy.

Reprocessing of transvaginal ultrasound transducers must align with current Australian and New Zealand reprocessing standards (AS 5369:2023), where applicable, in conjunction with manufacturer instructions for use and local infection control policies. The use of a transducer

cover does not replace the requirement for appropriate reprocessing, including high-level disinfection.

Refer to **ASUM & ACIPC Guidelines for Reprocessing Ultrasound Transducers (2026)**

5 The Examination

5.1 General

- Privacy and confidentiality are of the utmost importance. Components of the examination must be communicated to the patient at their level of comprehension.
- Patient dignity must be considered at all times.

5.2 Scan Technique

A transvaginal ultrasound is generally the preferred imaging modality for detailed assessment of the pelvic organs.

- A transvaginal ultrasound should be offered where clinically appropriate to patients able to consent to the procedure when presenting for a gynaecological ultrasound. The patient has the right to decline a transvaginal ultrasound. When a transvaginal ultrasound is contraindicated or declined, a transabdominal ultrasound with a full bladder should be performed.
- Where a transvaginal ultrasound examination is performed, a transabdominal ultrasound may also be undertaken if the uterus and ovaries are not adequately visualised, or where additional anatomical overview is required. This may be performed following the transvaginal examination. A full bladder is usually not required in this setting.
- The examination may be extended to include any or all approaches deemed necessary by the ultrasound practitioner performing the examination, subject to patient consent.
- The scope of pelvic assessment may vary depending on the clinical indication and may include routine pelvic ultrasound assessment or extended pelvic assessment where clinically indicated (see Section 6).
- Ultrasound examinations should be performed using the ALARA (As Low As Reasonably Achievable) principle, with consideration of the Thermal Index (TI) and Mechanical Index (MI), while obtaining the necessary diagnostic information. ^[21]

6 Pelvic Scanning

6.1 Scope of Pelvic Ultrasound Assessment

Pelvic ultrasound assessment may vary in scope depending on the clinical indication and findings during the examination. Examinations may therefore range from a routine pelvic ultrasound assessment to a more extended pelvic assessment where additional evaluation is clinically indicated. The assessment of the gynaecological organs is best performed using static and real-time imaging, with particular attention to each anatomical structure, its

appearance and relationship to adjacent structures, size, mobility and the eliciting of tenderness and/or reproduction of symptoms, all of which should be recorded.

In clinical practice, pelvic ultrasound examinations may range from a routine assessment of the uterus, ovaries and adnexa to a more extended assessment where clinically indicated, such as when deep endometriosis or other pelvic pathology requiring further evaluation is suspected. The scope of examination may also expand based on findings identified during the examination, where further evaluation is clinically appropriate.

The extent and emphasis of assessment should therefore be guided by the clinical indication and findings during the examination.

6.2 Routine Pelvic Ultrasound Assessment

A routine pelvic ultrasound examination may be performed utilising transabdominal, transvaginal and/or translabial approaches. A combination of approaches may be appropriate depending on the clinical indication and patient factors.

The following structures should be assessed:

Assessment and interpretation should be guided by recognised terminology and reference standards where applicable.

Structure	Typical assessment components may include:
Uterus and endometrium	• Size, shape, position and flexion. • Myometrium – echotexture and morphology, including presence of fibroids or features suggestive of adenomyosis. • Endometrium – thickness, appearance and/or classification, vascularity, presence of focal lesions. ^[22] • Serosal surface. • Where an intrauterine device is present, assess its position and relationship to the endometrial cavity and surrounding myometrium. • 3D assessment where clinically indicated. • Assessment of organ mobility and tenderness. • Identification of pregnancy where present.
Cervix	• Morphology and presence of lesions. • Cervical length where clinically relevant.
Ovaries	• Positive identification where possible. • Location and position.

	• Size and echotexture. • Follicle number and size, including the presence of dominant follicles or a corpus luteum. • Assessment of tenderness and mobility. • Presence of cystic, solid or complex ovarian or adnexal lesions, described using recognised terminology frameworks where appropriate.
Adnexa	• Adnexal masses and characteristics. • Fallopian tubes where fluid or tubal pathology is suspected.
Pouch of Douglas	• Free fluid. • Assessment for obliteration. • Presence of pathology.
Kidneys	• If a congenital uterine abnormality is identified, further clinical consideration should be given to assessment of the kidneys.

6.3 Extended Pelvic Ultrasound Assessment (e.g., suspected endometriosis or other pelvic pathology)

In some clinical situations a more comprehensive pelvic ultrasound assessment may be undertaken based on the clinical indication or findings identified during the examination. This commonly occurs where deep endometriosis or other pelvic pathology requiring further evaluation is suspected.

Such examinations are typically performed using a transvaginal approach, with additional transabdominal or translabial imaging where clinically indicated.

Extended pelvic ultrasound assessment should be performed by ultrasound practitioners with appropriate training and demonstrated competency relevant to the examination being undertaken.

If a comprehensive pelvic ultrasound assessment for endometriosis is requested but transvaginal ultrasound cannot be performed, a routine pelvic ultrasound examination by the transabdominal approach may be offered as an alternative examination, and this should be documented.

Where an extended assessment for suspected deep endometriosis is clinically indicated but cannot be completed, this limitation should be documented and further assessment or referral considered where appropriate.

International consensus recommendations, including those described by the International Deep Endometriosis Analysis (IDEA) group, should guide systematic evaluation of pelvic compartments where applicable.

Extended assessment may include additional evaluation of the following regions beyond the routine pelvic ultrasound assessment:

Pouch of Douglas

- Free fluid.
- Assessment of the sliding sign.
- Assessment for obliteration of the pouch of Douglas.
- Presence of lesions or pathology.

Posterior compartment

- Posterior vaginal wall.
- Pouch of Douglas.
- Uterosacral ligaments.
- Torus uterinus/retrocervical region.
- Rectosigmoid colon.
- Assessment for endometriosis lesions and adhesions.

Anterior compartment

- Bladder.
- Vesicouterine space.
- Ureters.
- Assessment for endometriosis and adhesions.

Lateral compartment

- Pelvic sidewall.
- Parametrium.
- Assessment for endometriosis and adhesions.

Kidneys

- Where extensive pelvic endometriosis, pelvic sidewall disease, ureteric involvement, or a large pelvic mass is suspected, the kidneys should be assessed for hydronephrosis.

6.4 Evaluation of Pelvic Pathology

Standard criteria should be adopted in evaluating ovarian, adnexal, uterine and endometrial pathology to support local consistency. Internationally recognised consensus terminology and structured reporting frameworks should be used where applicable to support consistent interpretation and clear clinical communication.

This description may include:

1. Site of origin, relationship to uterus and ovaries.
2. Dimensions.
3. Borders (well defined, irregular, poorly defined, thick walled).

4. Cystic, solid, mixed, loculated or septated.
5. Contents of cysts.
6. Echogenicity and architecture of solid areas.
7. Vascularity.
8. Mobility.

Further assessment of pelvic pathology may involve additional procedures such as saline infusion sonohysterography, hysterosalpingography with contrast sonography, 3D ultrasound and extended ultrasound protocols for the assessment of suspected deep endometriosis.

7 Documentation and Privacy

7.1 Documentation

Documentation of the examination should include both the clinical record and the imaging evidence supporting the findings. This may include:

1. Examination parameters
 - a. Technique used (e.g., transvaginal, transabdominal and/or translabial ultrasound), consent and the presence or refusal of an observer or chaperone where applicable.
2. Anatomical structures assessed according to the scope of examination performed.
3. Pathologic findings.
4. Imaging evidence supporting findings (e.g., representative images and, where appropriate, cine clips).

Where pathology is encountered, particularly adnexal masses or dynamic findings, documentation using a cine clip is recommended where feasible to support interpretation. This may include assessment of organ mobility, the sliding sign, or features suggestive of deep endometriosis.

7.2 Privacy and Health Information – Australia

In Australia, collection, storage, access and disclosure of ultrasound images and reports must comply with the Privacy Act 1988 and the Australian Privacy Principles, including obligations relating to health information security, access and retention.

7.3 Privacy and Health Information – New Zealand

In New Zealand, handling of ultrasound images and reports must comply with the Health Information Privacy Code 2020. Health information should be retained in accordance with the Health (Retention of Health Information) Regulations 1996, which require a minimum retention period of 10 years unless otherwise specified.

8 Report

While these guidelines do not prescribe the format of reporting, the following minimum elements should be recorded and made available to support diagnostic interpretation and

reporting in accordance with applicable scope of practice and clinical governance requirements.

A report must be produced for every diagnostic ultrasound examination undertaken. As a minimum, the report should document:

1. The clinical indication for the scan.
2. Examination parameters
 - a. Technique used (e.g., transvaginal ultrasound, transabdominal and/or translabial ultrasound).
3. Anatomical structures assessed according to the scope of pelvic ultrasound assessment performed.

For a routine pelvic ultrasound assessment this typically includes:

- a. Uterus, including the endometrium and myometrium.
- b. Ovaries and adnexa.
- c. Pouch of Douglas.

Where the examination is extended, this may also include:

- d. Anterior compartment.
- e. Posterior compartment.
- f. Lateral compartment.
4. Relevant findings, including details relating to any structure or pathology identified and any limitations of the examination where relevant.

Consistent use of standardised terminology supports clear and reproducible reporting of gynaecological ultrasound findings. Recognised terminology frameworks should be used where applicable to support consistent description and clinical communication. These may include consensus systems developed for gynaecological ultrasound practice such as MUSA^[17], IETA^[18], IDEA^[19] and IOTA^[20]. Where locally adopted, structured risk stratification systems such as O-RADS™ Ultrasound^[13] or IOTA ADNEX model may also be used to support communication and follow-up recommendations.

Where urgent or unexpected clinically significant findings are identified, these should be communicated promptly to the referring or responsible clinician in accordance with local clinical governance requirements, and the communication documented.

9 Quality Assurance and Continuing Competency

Ultrasound practitioners should maintain competency relevant to their scope of practice through appropriate continuing professional development and ongoing clinical practice.

Services providing gynaecological ultrasound should have appropriate quality assurance processes in place. These may include clinical audit, peer review, review of diagnostic discrepancies and adverse events, and monitoring of compliance with relevant infection prevention and safety requirements. Quality assurance activities should be undertaken in accordance with applicable professional, regulatory and organisational requirements.

10 Related/Supporting Documents

The following documents should be read in conjunction with this guideline:

1. ASUM & ACIPC Guidelines for Reprocessing Ultrasound Transducers (2026)
2. ASUM Policy on Vaginal Scanning by Sonographers
3. ASUM Discussion Paper on Consent

11 References

The following documents inform this guideline:

1. Diagnostic Imaging Accreditation Scheme. Standard 2.2: Consumer consent and information. Sydney: Australian Commission on Safety and Quality in Health Care; 2016. Available from: [Diagnostic Imaging Accreditation Scheme Standards | Australian Commission on Safety and Quality in Health Care](#)
2. Diagnostic Imaging Accreditation Scheme. Advisory DI21/05: Clarification of consent requirements. Sydney: Australian Commission on Safety and Quality in Health Care; 2021. Available from: [Advisory DI21/05: Clarification of consent requirements | Australian Commission on Safety and Quality in Health Care](#)
3. Medical Board of Australia. Sexual boundaries in the doctor–patient relationship. Melbourne: Australian Health Practitioner Regulation Agency; current edition. Available from: [Medical Board of Australia - Sexual boundaries in the doctor-patient relationship](#)
4. Office of the Australian Information Commissioner. Privacy Act 1988 (Cth). Canberra: Australian Government; current edition. Available from: [Privacy Act 1988 - Federal Register of Legislation](#)
5. Office of the Australian Information Commissioner. Australian Privacy Principles. Canberra: Australian Government; current edition. Available from: [Australian Privacy Principles | OAIC](#)
6. Australian Commission on Safety and Quality in Health Care. Reprocessing of reusable medical devices. Sydney: ACSQHS; 2023. Available from: [Reprocessing of reusable medical devices | Australian Commission on Safety and Quality in Health Care](#)
7. Health and Disability Commissioner. Code of Health and Disability Services Consumers' Rights. Wellington: New Zealand Government; current edition. Available from: [New Zealand, Code of Health and Disability Services Consumers' Rights Regulations 1996](#).
8. Office of the Privacy Commissioner (NZ). Health Information Privacy Code 2020. Wellington: New Zealand Government; 2020. Available from: [Office of the Privacy Commissioner | Health Information Privacy Code 2020](#)
9. New Zealand Government. Health (Retention of Health Information) Regulations 1996. Wellington: New Zealand Government; 1996. Available from: [Health \(Retention of Health Information\) Regulations 1996 \(SR 1996/343\) \(as at 10 July 2026\) Contents – New Zealand Legislation](#)

10. Medical Council of New Zealand. Informed consent. Wellington: MCNZ; 2021.
Available from: [Informed consent | Medical Council](#)
11. American Institute of Ultrasound in Medicine. AIUM Practice Parameter for the Performance of Ultrasound Examination of the Female Pelvis; 2024 revision. Laurel (MD): AIUM; 2024. Available from: [AIUM Practice Parameter for the Performance of Ultrasound of the Female Pelvis, 2024 Revision](#)
12. American College of Radiology; American College of Obstetricians and Gynecologists; American Institute of Ultrasound in Medicine; Society for Pediatric Radiology; Society of Radiologists in Ultrasound. ACR-ACOG-AIUM-SPR-SRU Practice Parameter for the Performance of Ultrasound of the Female Pelvis. Reston (VA): American College of Radiology; 2024. Available from: [Full Document Preview](#)
13. American College of Radiology. O-RADS™ Ultrasound Risk Stratification and Management System. Reston (VA): 2022. Available from: [O-RADS™ Ultrasound](#)
14. Sonography Canada. *Professional practice guidelines*. Toronto: Sonography Canada; current edition. Available from: [Professional Practice Guidelines - Sonography Canada](#)
15. Canadian Association of Radiologists. Practice guidelines and technical standards. Ottawa: Canadian Association of Radiologists; current edition. Available from: [Practice Guidelines - Canadian Association of Radiologists \(CAR\)](#)
16. Teede HJ, Misso ML, Costello MF, et al. International evidence-based guideline for the assessment and management of polycystic ovary syndrome 2023. Melbourne: Monash University; 2023. Available from: [Evidence-Based-Guidelines-2023.pdf](#)
17. Van den Bosch T, Dueholm M, Leone FPG, et al. Terms, definitions and measurements to describe sonographic features of myometrium and uterine masses: a consensus opinion from the MUSA group. *Ultrasound Obstet Gynecol*. 2015;46(3):284–298. doi:10.1002/uog.14806
18. Leone FPG, Timmerman D, Bourne T, et al. Terms, definitions and measurements to describe the sonographic features of the endometrium and intrauterine lesions: A consensus opinion from the IETA group. *Ultrasound Obstet Gynecol*. 2010;35(1):103–112. doi:10.1002/uog.7487
19. Guerriero S, Condous G, van den Bosch T, et al. Systematic approach to sonographic evaluation of the pelvis in women with suspected endometriosis, including terms, definitions and measurements: a consensus opinion from the International Deep Endometriosis Analysis (IDEA) group. *Ultrasound Obstet Gynecol*. 2016;48(3):318–332. doi:10.1002/uog.15955.
20. Timmerman D, Valentin L, Testa AC, Froyman W, Landolfo C, Kotlarz A, et al. Terms, definitions and measurements to describe the sonographic features of adnexal tumors: updated consensus opinion from the International Ovarian Tumor Analysis (IOTA) Group. *Ultrasound Obstet Gynecol*. 2026;67:702–724. doi:10.1002/uog.70191.

21. World Federation for Ultrasound in Medicine and Biology. WFUMB policy and statements on safety of ultrasound. *Ultrasound Med Biol.* 2013;39(5):926–929. doi:10.1016/j.ultrasmedbio.2013.02.007.
22. Van den Bosch T, Heremans R, Landolfo C, Epstein E, Leone FPG, Bourne T, Timmerman D, et al. ISUOG Consensus Statement on sonographic assessment of the endometrium: how to perform a gynecological ultrasound scan and report the findings. *Ultrasound Obstet Gynecol.* 2026;67(2):241–258. doi:10.1002/uog.70163.

12 Appendix A – Relevant Laws, Regulations and Guidance

This appendix provides high-level references to laws, regulations and authoritative guidance relevant to consent, decision-making, rights and privacy. It is not exhaustive and does not constitute legal advice. Practitioners and services must comply with current local legislation and organisational policies.

Australia – National

Instrument	Jurisdiction	Purpose / Relevance	Link
Privacy Act 1988 (Cth) & Australian Privacy Principles	Australia (Commonwealth)	Governs collection, storage, use and disclosure of personal and health information	Read the Australian Privacy Principles OAIC
Australian Charter of Healthcare Rights	Australia (National)	Sets out consumer rights including information, consent, dignity and privacy	Australian Charter of Healthcare Rights Australian Commission on Safety and Quality in Health Care
NSQHS Standards – Informed Consent	Australia (National)	Requires health services to have effective informed consent processes	Informed consent Australian Commission on Safety and Quality in Health Care
DIAS Standard 2.2	Australia (National)	Accreditation requirements for consumer consent and information	Diagnostic Imaging Accreditation Scheme Standards Australian Commission on Safety and Quality in Health Care
DIAS Advisory DI21/05	Australia (National)	Clarifies consent expectations for diagnostic imaging, including intimate procedures	Advisory DI21/05: Clarification of consent requirements Australian Commission on Safety and Quality in Health Care
Medical Board of Australia – Sexual Boundaries	Australia (National)	Professional boundary guidance relevant to intimate examinations	Medical Board of Australia - Sexual boundaries in the doctor-patient relationship

Australia – State and Territory (Contextual References)

Instrument	Jurisdiction	Purpose / Relevance	Link
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Consent to Medical and Healthcare Treatment Manual	New South Wales	Operational guidance on consent, capacity and substitute decision-making	Consent to Medical and Healthcare Treatment Manual
Guardianship and administration legislation	States and Territories	Framework for substitute decision-making where adults lack capacity	NSW - Guardianship Act 1987 No 257 - NSW Legislation QLD - Guardianship and Administration Act 2000 - Queensland Legislation - Queensland Government VIC - Guardianship and Administration Act 2019 legislation.vic.gov.au SA - Guardianship and Administration Act 1993 South Australian Legislation TAS - View - Tasmanian Legislation Online WA - WALW - Guardianship and Administration Act 1990 - Home Page NT - Northern Territory Legislation
Common law principles (including Gillick competence)	Australia	Capacity of minors to consent based on maturity and understanding	Capacity and health information ALRC Youth-health-resource-kit - Section 3- chapter 5

Note: State and territory legislation varies. Services should consult local policies and legal advice.

New Zealand

Instrument	Jurisdiction	Purpose / Relevance	Link
Code of Health and Disability Services Consumers' Rights	New Zealand	Establishes rights to be informed and to give informed consent	Code of Health and Disability Services Consumers' Rights — Health & Disability Commissioner
Health Information Privacy Code 2020	New Zealand	Governs handling of health information	Office of the Privacy Commissioner (NZ). Health Information Privacy Code 2020, as amended. Wellington:

			Office of the Privacy Commissioner; current edition.
Health (Retention of Health Information) Regulations 1996	New Zealand	Sets minimum retention periods for health records	Health (Retention of Health Information) Regulations 1996 (SR 1996/343) (as at 10 July 2026) Contents – New Zealand Legislation
Medical Council of New Zealand – Informed Consent	New Zealand	Professional standards for informed consent	Informed consent Medical Council
New Zealand Bill of Rights Act 1990 (s11)	New Zealand	Affirms the right to refuse medical treatment	New Zealand Bill of Rights Act 1990 No 109 (as at 30 August 2022), Public Act Contents – New Zealand Legislation