Cannabis Knowledge Foundation

Medical Cannabis and Driving Law

International Comparison: UK, Canada, Australia, Germany, Czech Republic and Switzerland

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Prepared by Cannavec.ai using the Cannabis Knowledge Foundation database

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Executive Summary

Six of the world's most advanced medical cannabis markets — the United Kingdom, Canada, Australia, Germany, the Czech Republic and Switzerland — have each developed distinct legal frameworks for cannabis and driving. Despite sharing the same underlying science, they have reached strikingly different conclusions about what a patient with a valid prescription may lawfully do behind the wheel.

The science is not in dispute: THC impairs driving for approximately three to eight hours after inhalation and longer after oral consumption. Yet THC remains detectable in blood for days or weeks after any impairment has resolved. The central legal challenge is how to write a rule that catches genuinely dangerous drivers without criminalising patients who are taking their medication correctly and are not impaired.

This report compares each country's approach, summarises the current legal position for medical cannabis patients, and proposes a policy framework — the 'layered impairment model' — that could resolve this tension in a scientifically defensible and publicly acceptable way.

Key finding: Only the United Kingdom and Germany offer statutory protections for medical cannabis patients who drive without impairment. Four of the six countries — Canada, Australia (with the exception of Tasmania), the Czech Republic and Switzerland — operate rules under which a patient could be prosecuted for driving lawfully after taking medication prescribed to them, provided only that detectable THC is present in their blood.

1. The Science of THC and Driving

1.1 The impairment window

Delta-9-tetrahydrocannabinol (THC), the principal psychoactive constituent of cannabis, impairs a range of driving-relevant abilities during the acute phase of intoxication. Controlled studies show impairment to reaction time, lane tracking, divided attention and hazard perception for approximately three to eight hours after inhalation, and for longer periods following oral or sublingual administration (edibles, oils, capsules) where absorption is slower and the peak effect is delayed.

Unlike alcohol, the relationship between blood THC concentration and degree of impairment is not linear and is not consistent across individuals. Two important factors drive this divergence:

- Tolerance: a chronic daily user — including a regular medical cannabis patient — develops significant functional tolerance. A patient with 5 ng/mL THC in their blood serum may drive no worse than a drug-free individual, while a first-time or occasional user may be meaningfully impaired at 2 ng/mL.
- Residual THC: THC is highly lipophilic and accumulates in adipose tissue, redistributing to the bloodstream over time. In chronic users, blood THC can remain detectable at low concentrations for many days or even weeks after the last dose, long after any subjective effect or measurable impairment has resolved.

1.2 The detection gap

This pharmacokinetic reality creates what researchers call the 'detection gap': the period during which a patient is biologically clean of any intoxicating effect but still positive on a blood or oral fluid test. For a medical cannabis patient taking a twice-daily oral preparation, the detection gap might span several days. For a patient vaporising dried flower daily, it may be several hours to several days depending on frequency of use.

The detection gap is the central policy problem. A law that prosecutes any driver with detectable THC will inevitably catch some patients who are not impaired. A law that requires proof of impairment may let some genuinely dangerous drivers escape if the impairment is not observable at roadside.

Recommended patient guidance (all jurisdictions): Wait at least six to eight hours after inhaling cannabis before driving, and at least eight to twelve hours after oral or sublingual products. Never drive if you feel any psychoactive effect. This guidance is conservative relative to the impairment window and provides a safety margin for the residual detection window.

2. Country-by-Country Analysis

2.1 United Kingdom

The law

The United Kingdom introduced a per se drug-driving offence under section 5A of the Road Traffic Act 1988, in force in England and Wales from March 2015 and in Scotland from March 2018. The specified limit for THC in blood is set by the Drug Driving (Specified Limits) (England and Wales) Regulations 2014 at 2 micrograms per litre (µg/L) — equivalent to 2 nanograms per millilitre (ng/mL). This is an effectively zero-tolerance threshold, set at a level intended to exclude accidental or passive exposure rather than to reflect a pharmacologically meaningful impairment threshold.

The medical defence

Section 5A(3) provides a statutory medical defence. A patient is not guilty of the per se offence if they can show: (1) the cannabis was prescribed or supplied by a person entitled to do so; (2) it was taken in accordance with prescriber directions; and (3) their driving was not impaired. The defence does not apply to the parallel section 4 offence of driving while unfit through drugs, which requires proof of impairment rather than a blood concentration threshold. Patients who are visibly impaired can still be prosecuted under section 4 regardless of the defence.

Practical position for patients

UK patients hold the strongest legal position of the six countries compared. The statutory defence means that a patient who can demonstrate lawful prescription and compliance is not guilty of the per se offence, even if blood THC exceeds the 2 µg/L limit. However, the defence is not automatic — the patient must adduce sufficient evidence to trigger it, and the prosecution may still attempt to rebut it. Patients should carry their prescription, be able to demonstrate compliance with dosing instructions, and should never drive when experiencing any psychoactive effect.

Key primary source: Road Traffic Act 1988, section 5A; Drug Driving (Specified Limits) (England and Wales) Regulations 2014 (SI 2014/2868).

2.2 Canada

The law

Canada introduced three per se THC offences under Part VIII.1 of the Criminal Code as amended by Bill C-46 (in force June 2018). Blood THC between 2 and 5 ng/mL within two hours of driving is a summary conviction offence carrying a $1,000 fine. Blood THC at or above 5 ng/mL within two hours of driving is a hybrid offence carrying up to ten years' imprisonment. A combined offence — THC at or above 2.5 ng/mL alongside blood alcohol at or above 50 mg/100 mL — also attracts hybrid liability. These limits apply to all drivers, medical and recreational.

No medical exemption

The Cannabis Act and the Criminal Code drug-impaired driving provisions contain no medical exemption. The Department of Justice Canada stated explicitly: 'The new law does not include a medical exemption; this is consistent with the Criminal Code's long-standing drug-impaired driving offence which has never exempted drivers who drive impaired by prescription drugs.' Medical patients are exempt only from the absolute zero-tolerance rules that apply to novice and commercial drivers — they are still subject to the three per se offences above.

A 2025 Newfoundland and Labrador Provincial Court decision (R. v. Smith) stayed a charge on the basis that the per se offence violated the Charter by not permitting evidence of non-impairment. This decision is persuasive authority only and is not binding nationally. The Criminal Code provisions remain in force.

Practical position for patients

Canadian patients face the most legally precarious position of the six countries. A patient taking a prescribed oral preparation and driving the following morning — when any subjective effect has long since resolved — may still have blood THC above 2 ng/mL and commit the summary offence. There is no defence, no medical exemption, and no requirement to prove impairment. The pending Supreme Court review of R. v. Smith may change this, but until then Canadian patients must exercise extreme caution.

Key primary source: Criminal Code of Canada, Part VIII.1; Blood Drug Concentration Regulations (SOR/2018-148).

2.3 Australia

The law

All Australian states and territories operate presence-based (zero tolerance) per se offences for THC in oral fluid or blood. Unlike alcohol-based drink-driving offences, these are not structured around a meaningful threshold — the offence is the mere detection of THC. This applies irrespective of whether the driver is clinically impaired and irrespective of whether the cannabis was lawfully prescribed.

Tasmania: the exception

Tasmania is the only Australian jurisdiction with a full statutory medical defence, confirmed in July 2021. A patient with a valid prescription who is not impaired may drive lawfully in Tasmania without committing the presence offence.

Victoria: partial reform

Victoria amended section 51 of the Road Safety Act 1986 from 1 March 2025 to give magistrates discretion not to cancel or disqualify the licence of a driver testing positive for THC who holds a valid prescription and was not impaired. This is sentencing discretion, not a defence — the offence still exists and charges can still be laid.

NSW and Queensland: reform pending

Reform bills are before both parliaments. NSW Premier Minns has expressed cautious support for an impairment-based model. As of May 2026 no bill has been enacted in either state.

Practical position for patients

Australian patients outside Tasmania face the most punitive position in this comparison. A lawfully prescribed patient who drives — even days after their last dose, when any effect has long since passed — commits the offence if THC is detectable in oral fluid at roadside. The community and legal pressure for reform is significant, but as of this publication most patients are advised by their clinicians not to drive at all while prescribed THC-containing products.

Key primary source: State and territory road transport legislation varies by jurisdiction. Victoria: Road Safety Act 1986, section 51 (as amended March 2025). Tasmania: Traffic Act 1925 (as amended).

2.4 Germany

The law

Germany made the most consequential policy shift of any country in this comparison in 2024. Following the partial legalisation of cannabis under the Konsumcannabisgesetz (CanG) of 1 April 2024, Germany enacted a statutory blood serum THC per se limit of 3.5 ng/mL under section 24a(1a) of the Straßenverkehrsgesetz (StVG), in force from 22 August 2024. This limit was set by an interdisciplinary expert group and represents a risk level considered comparable to the 0.2 per mille (permille) alcohol threshold applied to novice drivers — a level associated with meaningfully elevated accident risk but not with severe intoxication.

The 3.5 ng/mL threshold replaced an uncodified case-law limit of approximately 1.0 ng/mL, which courts had previously applied as the analytical detection threshold. The new limit acknowledges the pharmacokinetic reality that low concentrations of THC can remain detectable in blood serum without any associated impairment, particularly in experienced users.

The medical exemption (Medikamentenprivileg)

Section 24a(4) StVG provides that the per se offence does not apply where the THC in the driver's blood serum derives from the intended use of a specifically prescribed medicine — the so-called Medikamentenprivileg or medication privilege. This covers medical cannabis prescribed under the Medizinal-Cannabis-Gesetz (MedCanG) and removes administrative (Ordnungswidrigkeit) liability entirely. It does not

remove potential criminal liability under sections 315c and 316 of the Strafgesetzbuch (StGB), which require proof of actual impairment — but this represents the correct position: the administrative (traffic) offence should not apply to a compliant patient; the criminal (driving while incapable) offence should remain available if the patient is genuinely unfit to drive.

Practical position for patients

Germany has produced the best-designed legal framework of the six countries compared. The 3.5 ng/mL threshold is calibrated to the pharmacology of impairment rather than to analytical detection limits, and the medication privilege means that a compliant patient with a valid prescription faces no administrative liability. The layered criminal liability for actual impairment is the correct safety backstop. German patients should nonetheless be advised to wait an appropriate period after dosing and to consult their prescribing doctor about the interaction between their specific medication and driving fitness.

Key primary source: Straßenverkehrsgesetz § 24a (as amended by BGBl I Nr. 266, 16 August 2024); MedCanG (April 2024).

2.5 Czech Republic

The law

The Czech Republic operates a THC driving limit of 2 ng/mL whole blood under Government Decree No. 41/2014 Coll., in force from April 2014. This is a strictly enforced administrative cut-off. A higher criminal threshold — approximately 10 ng/mL, derived from Supreme Court case law (resolution 8 Tdo 449/2010) rather than a statutory provision — applies in criminal prosecutions. The gap between the administrative and criminal thresholds creates a zone in which a patient may face administrative proceedings for a relatively low blood THC concentration without criminal exposure, unless the level is significantly elevated.

No medical defence

Czech traffic law does not provide a statutory medical defence for prescribed cannabis. A valid prescription does not exempt a patient from prosecution or administrative proceedings if blood THC exceeds the 2 ng/mL threshold. This is a significant gap in a system that otherwise leads Europe in the generosity of its medical cannabis programme — the Czech Republic provides 90% statutory health insurance reimbursement for up to 30g per month, yet patients who drive risk administrative and potentially criminal consequences if THC is detected.

Practical position for patients

Czech patients are in a paradoxical legal position: they have among the most accessible and affordable medical cannabis programmes in Europe, but no legal protection whatsoever if they drive. Patients taking oral preparations are particularly vulnerable, as the detection window in blood can extend well beyond the period of any impairment. Clinicians are advised to discuss driving explicitly with patients and to document that advice.

Key primary source: Government Decree No. 41/2014 Coll.; Czech Criminal Code (resolution 8 Tdo 449/2010 for criminal threshold).

2.6 Switzerland

The law

Switzerland operates a zero-tolerance driving rule for THC under which a driver is deemed unfit to drive from a blood concentration of 1.5 ng/mL — the lowest formal threshold of the six countries compared. The threshold is set in the Road Traffic Act Ordinance and is applied regardless of whether the driver is clinically

impaired and regardless of whether the cannabis was medically prescribed. From as little as 1.5 ng/mL THC in blood, a driver is subject to criminal proceedings for driving while unfit and automatic licence revocation pending medical review.

Switzerland legalised medical cannabis from 1 August 2022, removing the requirement for exceptional authorisation from the Federal Office of Public Health (FOPH). Doctors may now prescribe cannabis-based medicines without prior regulatory approval. The medical cannabis programme is regulated by Swissmedic. However, the liberalisation of prescribing has not been accompanied by any corresponding liberalisation of the driving law.

The SGRM study and reform prospects

The Swiss Society of Legal Medicine (SGRM), commissioned by the Federal Roads Office (ASTRA), has examined the legal and scientific basis for the current THC threshold, considering both impairment-based and per se approaches. The Medical Cannabis Association Switzerland (MEDCAN) advises all patients taking THC-containing cannabis for medical purposes to refrain from driving entirely under the current legal framework. Reform is under active discussion but as of May 2026 no legislative change has been enacted.

Practical position for patients

Swiss patients face the strictest threshold of the six countries and have no medical defence. The 1.5 ng/mL threshold can be exceeded by a patient who consumed a legal CBD product the previous day, not just by a patient who took their prescribed THC medication. MEDCAN's advice to abstain from driving entirely reflects the severity of the legal exposure. The SGRM study is the most promising indicator that reform may follow the German model of a scientifically calibrated threshold, but this cannot be relied upon as at the date of this report.

Key primary sources: Swiss Road Traffic Act and Ordinance; MEDCAN guidance, February 2026; SGRM commissioned study; Swissmedic medical cannabis regulations in force August 2022.

3. Comparative Summary

The table below summarises the key parameters of each jurisdiction's approach to cannabis and driving.

Country	THC Limit	Medical Defence	Detection Method	Test Basis	If Impaired	Since
GB UK	2 µg/L blood	✅ Yes — 3 conditions	Saliva → blood	Per se (blood)	Separate s.4 offence	2015 (E&W)
CA Canada	2–5 ng/mL (summary) ≥5 ng/mL (serious)	❌ No	Saliva → blood	Per se (blood)	Separate impairment offence	2018
AU Australia	Any detectable (zero tolerance)	⚠️ Tasmania only	Oral fluid	Presence	Separate DUI offence	Varies by state
DE Germany	3.5 ng/mL blood serum	✅ Yes — prescribed use	Saliva → blood	Per se (serum)	Criminal §§315c/316	Aug 2024
CZ Czech Rep.	2 ng/mL whole blood	❌ No statutory defence	Saliva → blood	Per se (blood)	Criminal threshold ~10 ng/mL	2014

Country	THC Limit	Medical Defence	Detection Method	Test Basis	If Impaired	Since
CH Switzerland	1.5 ng/mL blood	❌ No (MEDCAN advises abstain)	Saliva → blood	Per se (blood)	Criminal proceedings	Long-standing

Country summaries

United Kingdom: A near-zero 2 µg/L blood threshold but with a meaningful statutory medical defence that protects compliant patients. The framework is legally sophisticated but the threshold remains set at a detection level rather than an impairment level, meaning some patients face prosecution before the defence can be raised. The two-offence structure (section 5A per se + section 4 impairment) is architecturally sound.

Canada: A tiered per se structure (2–5 ng/mL summary, ≥5 ng/mL hybrid) with no medical exemption. The most legally exposed patients are those taking oral preparations on a medical basis, for whom blood THC above 2 ng/mL the morning after dosing is not implausible. The pending constitutional challenge (R. v. Smith) may force reform.

Australia: Zero tolerance and predominantly no medical defence — the harshest position in this comparison relative to the generosity of the medical cannabis programme itself. The dissonance between a rapidly growing patient population (over 400,000 monthly active patients estimated in NSW alone) and a driving law that criminalises their lawful medication use is creating sustained political pressure for reform.

Germany: The most scientifically calibrated of the six frameworks. The 3.5 ng/mL threshold was set by an expert group to reflect actual risk rather than analytical detectability, and the medication privilege removes per se liability for compliant patients while retaining criminal liability for actual impairment. Germany is the model that other countries should examine most closely.

Czech Republic: A 2 ng/mL administrative limit and an approximately 10 ng/mL criminal threshold (from case law, not statute), with no medical defence. The paradox of a leading European medical cannabis programme — with 90% insurance reimbursement — and no driving protection for its patients is the defining feature of the Czech framework.

Switzerland: The strictest threshold (1.5 ng/mL) and no medical defence, in a country that liberalised prescribing in 2022. The threshold is so low that it can be exceeded by residual THC from legal CBD products. MEDCAN's advice that patients should not drive reflects the unsustainability of the current position. The SGRM study commissioned by ASTRA signals that reform is under consideration.

4. Proposed Policy Framework: The Layered Impairment Model

The following policy represents an attempt to reconcile two legitimate competing interests: the rights of medical cannabis patients who take their medication correctly and are not impaired while driving, and the legitimate public safety concern that some drivers under the acute influence of cannabis represent a genuine road safety risk.

4.1 The core principle

A person who is taking legally prescribed cannabis in accordance with their prescriber's instructions and who is not impaired at the time of driving should not be criminalised for driving. A person who drives while acutely impaired by cannabis — regardless of whether that cannabis is prescribed or recreational — should face legal consequence.

The German framework (3.5 ng/mL threshold + medication privilege + criminal impairment offence) represents the closest existing approximation of this principle. The UK framework (2 µg/L threshold + statutory medical defence + section 4 impairment offence) is the second closest. The proposed model below builds on these two frameworks.

4.2 The layered impairment model — five elements

Element 1: A scientifically calibrated per se threshold.

Set a blood THC concentration at a level associated with meaningful accident risk elevation in the general population — not at the analytical detection limit. The German expert group concluded 3.5 ng/mL serum THC represents this level for adults without tolerance. A conservative approach would set a threshold of 3.0–5.0 ng/mL whole blood, informed by independent scientific review, with a commitment to revise the threshold as the evidence base matures. This threshold should be clearly distinguished from the zero-tolerance approach and should be explicitly justified in the legislative record on pharmacological grounds.

Element 2: A statutory medical defence.

A person with a valid prescription, who took their cannabis as directed, and whose driving was not impaired, should have access to a statutory defence that removes criminal and administrative liability for exceeding the per se threshold. The UK section 5A(3) framework is the correct model. The defence should be structured so that sufficient evidence of prescription compliance shifts the evidential burden to the prosecution to disprove the defence beyond reasonable doubt.

Element 3: Retained criminal liability for actual impairment.

The medical defence should not apply — and should be explicitly excluded — where the driver is visibly impaired. A patient who is clinically impaired while driving their vehicle is dangerous regardless of their prescription status. The impairment offence (equivalent to the UK section 4 or the German StGB 315c/316) should remain fully available and should carry appropriate penalties. This is the safety backstop that makes the medical defence politically sustainable.

Element 4: Investment in impairment assessment.

A policy that relies on impairment rather than mere chemical presence requires investment in the capacity to assess impairment reliably. Drug Recognition Expert (DRE) training should be expanded, and standardised field sobriety testing protocols validated for cannabis-specific impairment should be adopted. Where an officer cannot establish impairment at roadside, the absence of a per se violation (because the driver is below the threshold or holds the medical defence) should be the outcome. This is consistent with the treatment of alcohol: a driver below the alcohol limit who passes sobriety tests is not prosecuted.

Element 5: Prescriber guidance and patient communication.

Any legislative framework that protects compliant medical cannabis patients should be accompanied by a duty on prescribers to advise patients explicitly about driving. This advice should be documented in the patient record. Patients should understand: the nature of the per se offence; the requirements of the medical defence; the recommended wait time between dosing and driving; and the absolute rule that driving while experiencing any psychoactive effect is both unsafe and unlawful, regardless of any defence.

4.3 Addressing non-patient concerns

The proposed model is not a blanket permission for cannabis patients to drive. It addresses the specific objection that zero-tolerance rules catch patients who are not impaired, while preserving full legal consequence for anyone who drives while actually impaired. The key responses to common concerns are:

- 'Patients could abuse the defence and drive while high.' The defence is not available where driving was impaired (Element 3). An impaired driver with a prescription commits the offence.
- 'Officers cannot tell the difference between impaired and non-impaired cannabis users.' This is addressed by Element 4 — investment in DRE training and standardised impairment assessment

tools. It is also a reason why the per se threshold (Element 1) remains important: it catches high-THC drivers who may not display obvious impairment to an untrained observer.

- 'A threshold will be gamed by patients who argue the science.' Setting the threshold at a pharmacologically defensible level (3.0–5.0 ng/mL) based on published road-safety research, and documenting that scientific basis in the legislative record, makes it legally resilient. Germany has successfully enacted and defended a 3.5 ng/mL threshold on exactly this basis.
- 'Medical cannabis patients should simply not drive.' For many patients — those managing chronic pain, PTSD, anxiety, or MS spasticity — the ability to drive is not a lifestyle preference but a functional necessity. A blanket 'don't drive' rule would effectively deny them the ability to work, attend medical appointments, or participate in ordinary life. This is neither proportionate nor consistent with how we treat other prescribed medications that may cause residual sedation.

4.4 Summary comparison of the proposed model

Approach	Pro-patient case	Public safety concern	Current countries
Zero tolerance (any detectable THC)	Simple to enforce	Penalises legitimate patients long after impairment has passed	Australia (most states), France
Per se limit (e.g. 2 ng/mL)	Bright-line rule; easy prosecution	Residual THC ≠ impairment; heavy users may exceed limit while sober	UK, Czech Republic, Switzerland
Higher per se limit (e.g. 3.5–5 ng/mL)	Better calibrated to acute impairment window	Some acutely impaired users may be below the threshold	Germany (3.5 ng/mL); some US states (5 ng/mL)
Medical defence (prescription + no impairment)	Protects legitimate patients; retains impairment as the real test	Harder to prosecute; subjective impairment assessment required	UK, Germany, Tasmania (AU)
Effect-based only (impairment test, no per se)	Fairest — tests actual fitness to drive	Inconsistent enforcement; harder to prosecute without a number	Proposed reform direction (AU, CA discussions)
Impairment + per se (layered approach)	Provides both a quick enforcement tool and a fair safety net	More complex legislation; requires robust DRE training	Proposed best practice (see policy section)

The layered impairment model occupies the bottom row of the table above. It combines the enforcement clarity of a per se threshold with the fairness of a medical defence, and retains robust criminal liability for genuine impairment. It is already operative in Germany, and partially operative in the UK. It represents the direction that Australia, Canada, the Czech Republic and Switzerland should pursue.

5. Conclusion

The international evidence is clear: zero-tolerance driving laws for THC treat residual chemical presence as equivalent to impairment, a position that is pharmacologically indefensible and increasingly legally contested. Medical cannabis patients — who have been prescribed a lawful medicine by a registered clinician — face prosecution in the majority of the countries examined for a state of affairs (detectable THC in their blood) that has nothing to do with their fitness to drive.

Germany has demonstrated that a different approach is workable. A scientifically calibrated threshold, a medication privilege for compliant patients, and retained criminal liability for actual impairment can coexist in a road safety framework that is both fair to patients and defensible to the public. The United Kingdom has arrived at a structurally similar outcome through a different route — the per se offence with a statutory medical defence.

The remaining four countries are at different stages of the political process. Australia has the most urgent case for reform, with a patient population in the hundreds of thousands and driving laws that have not kept pace with the scale of lawful prescribing. Canada faces a growing constitutional challenge to its no-exemption position. The Czech Republic has the sharpest internal contradiction — a leading medical programme without driving protection. Switzerland is beginning the evidence-gathering that may precede reform.

The proposed layered impairment model is not radical. It does not permit impaired driving. It does not exempt patients from scrutiny. It makes the test for criminal liability the right one — actual fitness to drive — rather than the wrong one — the pharmacokinetic accident of when THC happened to become undetectable.

Sources and References

This report draws primarily on the Cannabis Knowledge Foundation database, compiled and verified by Cannavec.ai. Country-specific primary sources are cited within each section. The following represent the principal primary legislative and regulatory instruments consulted.

United Kingdom

- Road Traffic Act 1988, section 5A (inserted by Crime and Courts Act 2013, section 56)
- Drug Driving (Specified Limits) (England and Wales) Regulations 2014 (SI 2014/2868)
- GOV.UK Drug Driving Guidance for Healthcare Professionals

Canada

- Cannabis Act (S.C. 2018, c. 16)
- Criminal Code of Canada, Part VIII.1 (Drug-Impaired Driving)
- Blood Drug Concentration Regulations (SOR/2018-148)
- Department of Justice Canada — Drug-Impaired Driving FAQ

Australia

- Road Safety Act 1986 (Victoria), section 51 (as amended March 2025)
- Traffic Act 1925 (Tasmania) — medical defence provisions
- State and territory road transport legislation (NSW, QLD, WA, SA, NT, ACT)

Germany

- Straßenverkehrsgesetz (StVG), § 24a (as amended BGBl I Nr. 266, 16 August 2024)
- Konsumcannabisgesetz (CanG) — in force 1 April 2024

- Medizinal-Cannabis-Gesetz (MedCanG) — in force 1 April 2024
- Strafgesetzbuch (StGB), §§ 315c, 316

Czech Republic

- Government Decree No. 41/2014 Coll. (drug driving blood concentration cut-offs)
- Czech Supreme Court resolution 8 Tdo 449/2010 (criminal threshold case law)
- Act No. 361/2000 Coll. (Road Traffic Act)

Switzerland

- Swiss Road Traffic Act (Strassenverkehrsgesetz, SVG) and associated Ordinance
- MEDCAN guidance — February 2026 (Medical Cannabis Association Switzerland)
- SGRM study commissioned by Federal Roads Office (ASTRA) — December 2024
- Swissmedic — cannabis as medicine regulations (in force August 2022)

Scientific literature

- Driving Under the Influence and Workplace Drug Testing: Cannabis Law and Policy — Cannabis Knowledge Foundation database
- Cannabis-based medicines and medical fitness-to-drive: current legal issues in Switzerland — Clinical Therapeutics, 2024
- Cannabis Knowledge Foundation — UK Legal Context, Canada Legal Framework, Australia Legal Framework, Germany Legal Framework, Czech Republic Legal Framework (all sourced May 2026)

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