Essays

Medical Cannabis in the Context of the European Convention on Human Rights: Balancing Personal Autonomy and the Interests of Society

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ABSTRACT: The article analyses the problem of medical cannabis within the framework of human rights and the jurisprudence of the European Court of Human Rights. The authors point to the tension between the individual's right to autonomy and relief from suffering and the State's obligation to protect public health. An analysis of the case law of the European Court of Human Rights shows that although the choice of treatment falls within the scope of the right to private life, States are granted a wide margin of appreciation – justified by the lack of a European consensus and the need to protect against risky therapies. In this context, the question arises as to whether, with the increasing liberalisation of regulations and growing social acceptance of medical cannabis, the Court, when adjudicating cases concerning access to medical cannabis, will lean more towards individual autonomy or towards the wide margin of appreciation of Member States in ensuring the protection of the public interest.

KEYWORDS: medical cannabis; European Convention on Human Rights; European Court of Human Rights; margin of appreciation; individual autonomy; public health; right to privacy.

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1. Introduction

The debate on medical cannabis in Europe has for years been balancing between two seemingly contradictory values: the individual human right to health protection, including pain treatment, and the public interest in protecting society from the potential dangers of psychoactive substances. This issue is not solely a medical or political one – it is also the subject of intense legal reflection, particularly in the context of the European Convention on Human Rights (hereinafter: ECHR, Convention). It is the Convention, interpreted and applied by the European Court of Human Rights (hereinafter: ECtHR, Court), that becomes the arena where fundamental values clash: the individual's right to autonomy and self-determination and the ECHR's Member States' (hereinafter: Member States, States) obligation to ensure public safety and health.

The importance of this debate is particularly evident today, in an era of dynamic medical progress, growing patient awareness, and frequent attempts to seek alternatives to traditional pharmacological therapies. In recent years, more and more European countries, from Malta to Luxembourg to Germany, have decided to liberalise their regulations on cannabis, both for medical and recreational use.[1] At the same time, other countries maintain strict regulations, allowing no exceptions to the ban on cannabis. The lack of a uniform standard leads to a situation where a patient's rights to access treatment essentially depend on their place of residence, which in itself raises questions about equality and fairness within the Council of Europe system.

The subject of this study is an analysis of the issue of medical cannabis in the light of the European Convention on Human Rights. Against this background, several key research questions arise. Firstly, can the denial of access to medical cannabis, in a situation where other therapies prove ineffective, be seen as a violation of the right to life (Article 2 of the ECHR), the prohibition of inhuman or degrading treatment (Article 3 of the ECHR) or the right to respect for private and family life (Article 8 of the ECHR)? Secondly, how much discretion should States have in shaping health policy in this area, and where is the line between their autonomy and their responsibility to protect individual rights? Finally, is there a European consensus on the use of medical cannabis that could prompt the Court to set new standards for the protection of human rights?

The analysis is based on a dogmatic-legal analysis of the provisions of the European Convention on Human Rights and the case law of the European Court of Human Rights. Although the European Convention on Human Rights does not expressly mention the right to health protection, it is one of the most important instruments for assessing the admissibility of restrictions or the obligation to ensure access to specific forms of therapy. The Convention was intended to be a 'living' document, and its interpretation should evolve in line with changing social and medical realities. The study covers not only cases directly related to medical cannabis, but also the broader bioethical context in which the Court had to balance the individual's right to autonomy with the public interest. Particular attention was paid to the interpretative rules applied by the Court – the principle of evolutionary interpretation of the Convention, the margin of appreciation, the principle of proportionality and the positive obligations of States. The analysis was supplemented by a review of national regulations on medical cannabis and the results of empirical research

[1] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Cannabis legalisation in Europe: A state of flux*, 2022.

conducted in 2025 on a group of law and medical science students in Poland, concerning legal awareness and social acceptance of this form of therapy.
This analysis allows us to grasp the multidimensional nature of the problem – on the one hand, the legal reconstruction of the right to health protection under the ECHR, on the other hand, the practical consequences of diverse regulations in Europe, and finally, the role of the Court in setting standards for the protection of individuals in the face of dynamic social and medical changes. As a result, the aim of this study is to show how the ECtHR balances the individual's right to dignified treatment with the public interest, and what the future directions of case law in this area might be.

2. The Right to Health Protection in the Context of the European Convention on Human Rights – Analysis of Articles 2, 3 and 8 of the Convention in the Light of the Right to Treatment and Pain Relief

2.1. The Dichotomous Nature of the Human Rights Protection System and the Right to Health Protection

At the international level, the right to enjoyment of the highest attainable standard of health has been enshrined in numerous pivotal international legal instruments. These range from the Constitution of the World Health Organisation of 1946[2] to documents of the regional systems of the Council of Europe and the European Union, such as European Social Charter[3] and Charter of Fundamental Rights of the European Union[4]. Alongside the dynamic progress of medicine and the growing social awareness, this right has undoubtedly acquired a fundamental rank, as recognized by the Committee of Social Rights, which characterises ensuring an adequate level of health care as "a prerequisite for the preservation of human dignity".[5]
For example this normative development is reflected in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[6] It defines right to health as "the right to the enjoyment of the highest attainable standard of physical and mental health". Although Article 12 ICESCR cannot be understood as a right to be healthy, it obliges UN Member States to create the conditions necessary for individuals to attain the best possible level of health, as clarified by the Committee on Economic, Social and Cultural Rights in General Comment No. 14 (2000).[7]
Although subject to progressive realisation under Article 2(1) ICESCR,[8] the right to health entails concrete and measurable positive obligations. States are required to take deliberate and targeted steps, using the maximum of available resources, including the allocation of adequate funding to essential health services, the adoption of appropriate legislative and regulatory frameworks, and the establishment of effective

[2] World Health Organisation, *Constitution of the World Health Organisation, Article 1,* 22 July 1946.
[3] Council of Europe, *European Social Charter (revised)*, *Article 11,* 3 May 1996.
[4] European Union, *Charter of Fundamental Rights of the European Union, Article 35,* 7 December 2000.
[5] *Collective Complaint FIDH v. France*, app. no. 14/2003, 3 November 2004, § 31.
[6] International Covenant on Economic, Social and Cultural Rights, *Article 12*, 1966.
[7] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14*, *The right to the highest attainable standard of health*, 11 August 2000.
[8] International Covenant on Economic, Social and Cultural Rights, *Article 2*, 1966.

institutional safeguards. In addition, certain obligations – such as non-discriminatory access to healthcare and the provision of minimum core health services – are of immediate effect.[9]

Against this broader international background, the inclusion of the present legal as well as ethical dilemma within the framework of the ECHR - particularly with regard to the permissibility of employing unconventional therapeutic measures in antinociceptive treatment – is by no means incidental. The aforesaid is, in fact, justified by the Convention's indirect – yet evolving – approach to health-related concerns. A defining characteristic of the Strasbourg system of human rights protection is its dichotomous character.[10] This dualism presupposes the distinction of two categories of rights: first-generation rights (civil and political rights) and second-generation rights (social, economic and cultural rights), within the latter the right to health protection is unquestionably situated.[11] In the 1950s, during the intensive process of drafting the provisions of the Convention in the light of the then-prevailing political situation in post-war Europe, the rights and freedoms pertaining to economic and social rights were consciously omitted.[12] Consequently, in one of the most significant instruments of the Council of Europe, it is impossible to directly identify a guarantee norm imposing upon Member States the duty to enforce and implement measures ensuring the health protection of patients.[13]

Nevertheless, considering the inherent indivisibility[14] and the interrelation of all human rights and freedoms,[15] and simultaneously bearing in mind the specific nature of the Convention, as well as the dynamic interpretation of its provisions,[16] the above does not contradict the recognition that an attempt at the reconstruction of this right within the framework of the Convention values is indeed feasible. In fact, the European Court of Human Rights has repeatedly adjudicated in cases concerning medical malpractice or breaches of medical-legal regulations, directly referring to the following personal rights: the right to life (Article 2), the prohibition of torture or inhuman or degrading treatment or punishment (Article 3), and, with particular emphasis, the right to respect for private and family life (Article 8).[17]

In this regard, on the basis of Article 2 of the Convention, Professor Leszek Garlicki distinguished a specific rule of reconstructing the right to health protection in the context of the Convention, taking into account the jurisprudence of the Strasbourg Court.[18] The above-mentioned principles may also be applied *in abstracto* to each of the rights under discussion herein, namely Article 3 and 8 of the Convention. The

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[9] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14*, *The right to the highest attainable standard of health*, 11 August 2000.

[10] R. TABASZEWSKI, *Prawo do zdrowia w systemach ochrony praw człowieka,* Lublin*,* 2016*,* 113.

[11] V. LEARY, *The right to health in International Human Rights Law*, in *Health and Human Rights*, Massachusetts, 1994, 26.

[12] L. GARLICKI, *Prawo do ochrony zdrowia na tle „prawa do życia" (uwagi o aktualnym orzecznictwie Europejskiego Trybunału Praw Człowieka),* in *Dookoła Wojtek… Księga pamiątkowa poświęcona Doktorowi Arturowi Wojciechowi Preisnerowi*, Wrocław, 2018, 211.

[13] R. TABASZEWSKI, *Prawo do zdrowia w systemach ochrony praw człowieka,* cit., 113.

[14] F. JACOBS, R. WHITE, C. OVEY, *The European Convention on Human Rights*, Oxford, 2010.

[15] L. GARLICKI, *Konwencja o Ochronie Praw Człowieka i Podstawowych Wolności Tom I: Komentarz do artykułów 1-18*, Warsaw, 2010.

[16] L. GARLICKI, K*onwencja o Ochronie Praw Człowieka i Podstawowych Wolności Tom I: Komentarz do artykułów 1-18*, cit., 482.

[17] R. TABASZEWSKI, *Prawo do zdrowia w systemach ochrony praw człowieka,* cit., 113.

[18] L. GARLICKI, *Prawo do ochrony zdrowia na tle „prawa do życia" (uwagi o aktualnym orzecznictwie Europejskiego Trybunału Praw Człowieka),* cit., 212.

principal thesis expressed by Professor Garlicki, and simultaneously exemplifying the established jurisprudence of the Court,[19] is the already noted statement that "the right to health protection does not, as such, belong to the rights and freedoms guaranteed by the Convention". Pursuant to the foregoing, any attempt to invoke the right to health protection within the framework of the Convention is of an indirect nature, where such a right may only be claimed through the demonstration of violations of other Convention guarantees. Therefore, the adjudication of cases concerning violations in this respect must be examined by the Court *ad casum*, while refraining from "formulating standards of a general nature".[20]

2.2. The Right to Life (Article 2 of the Convention)

The right to life, guaranteed by the Article 2 of the Convention,[21] appears as intuitively the closest to the right to health protection. The functional connection of these two values becomes apparent in situations where a potential threat to an individual's life arises as a direct consequence of medical negligence.[22] However, the unequivocal classification of such situations as violations of the right to life attributable to the State remains relatively rare, since medical negligence is typically the result of individual acts of medical stuff and, in the absence of a systemic failure of the healthcare system, lacks the necessary causal connection with States action or omission under Article 2.

Accordingly, the Court has primarily examined whether the State has established an adequate legal and institutional framework to safeguard life of those within State's jurisdiction. This includes enacting the adoption of regulatory frameworks that require hospitals to implement appropriate measures to safeguard patients' lives, as well as the establishment of an effective and independent judicial system capable of determining the causes of death of patients under medical care and ensuring accountability for those responsible.[23] This reasoning reflects the idea of the State's positive obligations, which, in the spirit of the effectiveness of the Convention's provisions, obliges the State "to take the necessary measures to ensure the practical enjoyment of specific Convention rights, as well as to establish effective mechanisms for their protection".[24]

At the same time, in the case of *Panaitescu v. Romania,* the Court emphasised that financial constraints of the State cannot justify negligence in ensuring the practical and effective protection of the individual's right to life. Nevertheless, it is still accurate to state that although the Court has not excluded that acts or omission of public authorities within the sphere of public health policy may occasionally give rise to their responsibility under Article 2 of the Convention,[25] even in cases where medical negligence has been established, it finds a violation of this provision only where the applicable legal framework failed to secure adequate legal protection of an individual's life. Hence, in the light of Article 2 of the Convention, the issue

[19] ECtHR, *Lopes de Sousa Fernandes v. Portugal*, app. no. 56080/13, 19 December 2017, § 165.

[20] L. GARLICKI, *Prawo do ochrony zdrowia na tle „prawa do życia" (uwagi o aktualnym orzecznictwie Europejskiego Trybunału Praw Człowieka),* cit., 212.

[21] Council of Europe, *European Convention on Human Rights, Article 2 (Right to life)*, 4 November 1950.

[22] R. TABASZEWSKI, *Prawo do zdrowia w systemach ochrony praw człowieka*, cit., 115.

[23] E. WICKS, *The role of the right to life in respect of deaths caused by negligence in the healthcare context*, in *Medical Law Review*, Oxford, 2024, 84.

[24] L. GARLICKI, *Prawo do ochrony zdrowia na tle „prawa do życia" (uwagi o aktualnym orzecznictwie Europejskiego Trybunału Praw Człowieka),* cit., 212.

[25] ECtHR, *Dodov v. Bulgaria*, app. no. 595448/00, 17 January 2008, §§ 79-80.

of pain-relief is of secondary character, with the State being primarily obliged to safeguard the individual's right at "a level indispensable for the preservation of the [his or her] life".[26]

2.3. The Prohibition of Torture, Inhuman or Degrading Treatment on Punishment (Article 3 of the Convention)

The right to treatment and pain relief as such has been expressly recognised by the Parliamentary Assembly of the Council of Europe in its Recommendation of 25 June 1999 concerning the protection of human rights and the dignity of the terminally ill and the dying (Recommendation No. 1418), pointing to the special necessity of providing them with appropriate palliative care.[27] Within the Council of Europe framework, the issue of potential systemic shortcomings in this regard is assessed under Article 3 of the Convention, which lays down the absolute prohibition of torture, inhuman or degrading treatment or punishment.[28]

The matter of an individual's experience of pain, coupled with the State's refusal to provide access to non-standard means with the potential to relieve it, constitutes a contract subject of the Court's discussion in the sphere of bioethics. In this respect, the Court has explicitly underlined that Article 3 of the Convention cannot be interpreted as imposing upon the State an obligation to guarantee patients access to every treatment option they may choose, even if there exist premises pointing to its potential effectiveness. This finding applies directly to situations concerning non-standard therapies, such as treatment with medical cannabis. Within the margin of appreciation accorded to States, and bearing in mind that Convention does not oblige States to "alleviate the disparities between the levels of health care available in various countries",[29] it falls within the competence of national authorities to decide whether, and to what extent, to authorise a given substance for medical use. Provided that the State ensures access to treatments of recognised effectiveness and does not deprive patients of basic health care, the absence of access to therapy chosen by the individual – even one potentially alleviating suffering – does not, in itself, amount to inhuman or degrading treatment within the meaning of Article 3 of the Convention.

2.4. The Right to Respect for Private and Family Life (Article 8 of the Convention)

The issue of the right to pain relief, intrinsically linked to human dignity, constitutes an object of the Court's case law, particularly under Article 8 of the Convention, enshrining the right to respect for the private and family life of a person.[30] Namely, in line with the Court's well-established jurisprudence, when the treatment of a given person does not reach the threshold of severity required by Article 3 of the

[26] M. Piechota, *Konstytucyjne prawo do ochrony zdrowia jako prawo socjalne i prawo podstawowe*, in *Roczniki Administracji i Prawa. Teoria i* praktyka, Sosnowiec, 2012, 96.
[27] Parliamentary Assembly, *Protection of the human rights and dignity of the terminally ill and the dying*, *Recommendation 1418*, 25 June 1999.
[28] Council of Europe, *European Convention on Human Rights, Article 8 (Right to Respect for Private and Family Life)*, 4 November 1950.
[29] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012., also: *N. v. the United Kingdom*, § 44.
[30] Council of Europe, *European Convention on Human Rights, Article 8 (Right to Respect for Private and Family Life)*, 4 November 1950.

Convention, it should be assessed in terms of a potential interference with interests protected under Article 8.[31]

In view of the Court's settled case-law, reflecting the dynamic interpretation of the Convention as a living instrument, the seemingly succinct wording of Article 8 has been constructed as covering a remarkably wide range of rights. The Convention's protective scope expressly includes private life, family life, the home and correspondence. At the core of these guarantees lies the fundamental purpose of Article 8, i.e. to protect the individual against arbitrary interference by public authorities.[32]

It should be emphasised, however, that this protection – although broad – is by no means absolute. The liberty-oriented nature of Article 8, akin to Article 9, 10 and 11 of the Convention – distinguishes it from Articles 3, which is absolute in character. The structure of Article 8 contains a limitation clause, which – as an expression of the need to balance the rights of the individual against the public interest – allows for the interference with the protected sphere of freedoms in exceptional circumstances. The legitimacy of such interference by the State is conditional upon its being provided by law, pursuing a legitimate aim, and being necessary in a democratic society. A case-based explanation of how this protection mechanism operates will be further elaborated in a subsequent part of the article (see: Analysis of the case law of the European Court of Human Rights concerning the right to health protection and the application of unconventional therapeutic measures).

The particular regulatory breadth of Article 8 is most easily discernible in the rich body of the Court's case-law, which has developed on the basis of the first of its protected components, namely private life. The above correlation derives from the very nature of this right, where the notion of private life is understood in the Court's jurisprudence as a broad term, not susceptible to exhaustive definition.[33] It encompasses, above all, values concerning the autonomy of the individual and his or her freedom of decision making – a particular mode of "living in accordance with one's own wishes and without the control of others".[34] Within this field there are also such rights as the right to establish and maintain relationships with others[35] and the mutual contacts of individuals in the public sphere.[36] In addition, within this domain the Court has devoted particular attention to issues relating to the quality of the individual's life[37] and to the safeguarding of his or her physical, psychological and moral integrity.[38] In this regard, one cannot fail to mention the right to express informed consent to the provision of medical treatment, which remains in close connection with the said integrity of the person.[39] All of the above elements, although seemingly no directly connected with the individual's state of health, in fact create a common foundation of values, the full and effective enjoyment of which by a person in suffering is conditioned upon his or her freedom from pain and, consequently, upon the possibility of applying appropriate therapeutic measures with a view to its alleviation.

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[31] M. NOWICKI, *Wokół Europejskiej Konwencji Praw Człowieka*, Warsaw, 2021, 795.
[32] W. SCHABAS, *The European Convention on Human Rights: A Commentary*, Oxford, 2015, 367.
[33] ECtHR, *Costello-Roberts v. United Kingdom*, app. no. 13134/87, 25 March 1993, § 36.
[34] M. NOWICKI, Wokół Europejskiej Konwencji Praw Człowieka, cit., 800.
[35] ECtHR, *Bigaeva v. Greece*, app. no. 26713/05, 28 May 2009, § 22.
[36] ECtHR*, Von Hannover v. Germany*, app. no. 59320/00, 24 June 2004, § 95.
[37] ECtHR, *Pretty v. the United Kingdom*, app. no. 2346/02, 29 April 2022, § 65.
[38] ECtHR *E.S. v. Sweden*, app. no. 5786/08, 21 June 2012, § 40.
[39] *V.C. v. Slovakia*, app. no. 18968/07, 8 November 2011, § 146.

An outward expression of individual autonomy lies in the presumption that everyone can freely pursue the development and fulfillment of his or her personality and establish and develop relationships with the other persons and the outside world.[40] The State's duty in this regard is reduced to recognising the individual's right to be left alone, which belongs to the sphere of negative obligations incumbent upon the State.[41] This correlation finds its clearest reflection in the premises adopted by the Court in cases concerning the individual's freedom of choice with respect to ending his or her life. In Pretty v. the United Kingdom, the guiding thread of the judgment was the recognition that the legal prohibition on the applicant's undergoing euthanasia – being an emanation of her will to avoid a condition perceived by her as degrading and painful – could de facto be regarded as an interference with the right to respect for private life.[42] An identical correlation may also be discerned in the judgments in *Haas v. Switzerland* and *Gross v. Switzerland*, the common denominator of which is the consideration of the necessity of respecting the unimpeded will of the individual – even where that may entail adverse consequences for the person concerned.[43]

Transposing the foregoing considerations onto the subject-matter under discussion, individual autonomy assumes a dual character in the perspective presented. On the one hand, the potential limitations arising from experienced pain prevent the individual from the full realisation of private life, thereby affecting the scope of enjoyment of the freedoms protected under Article 8 of the Convention. On the other hand, the legal restriction of access to medical cannabis for antinociceptive treatment narrows the possibility of making an autonomous choice of a desired therapeutic measure, based on informed consent. Both factors directly affect the quality of the individual's life, which prompts the question of the legitimacy of restrictions concerning alternative methods of pain treatment within the framework of healthcare provisions.

When addressing matter of health, the Court has explicitly indicated that, although the Convention does not guarantee any specific level of medical care, the normative content of private life encompasses the individual's physical, psychological, and moral integrity.[44]

Furthermore, it has added that the State is also under a positive obligation to secure to its citizens their right to effective respect for this integrity.[45] Against this background, in order to ensure the full realisation of the State's obligations, the State is required to respect, protect, and implement/fulfil[46] – among other rights – an individual's right to physical, psychological, and moral integrity. The realisation of this latter aspect reflects the idea of positive obligations of the State, under which the State is required to undertake active measures aimed at the full fulfilment of the right in question. This has been illustrated through legislative endeavours by examining whether the existing legal framework in the relevant area provides adequate protection of these rights. For instance, in *Tysiąc v. Poland*, the Court assessed whether the

[40] W. SCHABAS, *The European Convention on Human Rights: A Commentary*, cit., 370.
[41] S. Warren, L. Brandeis, *The Right to Privacy*, in *Harvard Law Review,* 4(5), Massachusetts, 1890.
[42] ECtHR, *Pretty v. United Kingdom*, app. no. 2346/02, 29 April 2002, § 67.
[43] ECtHR, *Hass v. Switzerland*, app. no. 31322/07, 20 January 2011, § 51; *Gross v. Switzerland*, app. no. 67810/10, 14 May 2013, § 58-60.
[44] W. SCHABAS, *The European Convention on Human Rights: A Commentary*, cit., 372.
[45] ECtHR, *Glass v. United Kingdom*, app. no. 61827/00, 9 March 2004, §§ 74-83.
[46] J. F. AKANDJI-KOMBE, *Positive obligations under the European Convention on Human Rights. A guide to the implementation of the European Convention on Human Rights*, Strasbourg, 2007.

State's legislation legalising abortion established an effective legal framework enabling women to genuinely access and exercise this right.[47]

In the light of the above, a hypothetical refusal to grant a suffering individual access to medical cannabis, in the face of the effectiveness of other, previously applied therapeutic measures, may undeniably give rise to serious consequences for the integrity of the person, both in its physical and psychological dimensions. According to the established case-law of the Strasbourg Court, such a factual situation may potentially be classified either as a restriction on the applicant's choice in the sphere of medical treatment - which would fall to be examined as an interference with their right to respect for private life – or as an allegation of the State's failure to fulfil its obligation to provide an adequate legal framework safeguarding the rights of persons in suffering, which would fall to be analysed in terms of the positive obligation of the State to ensure respect for their private life.[48] Although the Court does not consider it necessary to draw a distinction between these two circumstances, it consistently emphasised that in each instance "it is necessary to strike a fair balance between the competing interest of the individual and of the community as a whole".[49] In resolving the foregoing, the interpretative principles of the Convention play an exceptionally significant role, and these will constitute the subject of the subsequent analysis.

3. Principles of Interpretation of the European Convention on Human Rights

3.1. Introduction

The Convention itself does not prescribe how its provisions are to be interpreted. It should be noted, however, that a distinctive feature of the Convention is that most of its provisions are formulated in broad terms, thereby allowing for a wide scope of interpretation. Against this background, the Court has developed a body of interpretative principles which enable the effective realisation of the Convention's objective, as expressed in its Preamble, namely the universal and effective protection of human rights.[50] Some of these principles, frequently invoked by the Court in cases relating to the right to health protection, will be examined in this subsection.

3.2. The Evolutive Interpretation of the European Convention on Human Rights

The European Convention on Human Rights entered into force in 1953, more than seventy years ago. With the passage of time and the rapid transformation of societies, the understanding of concepts and notions contained in the Convention as they were conceived at the time of its drafting would be unacceptable in today's world. Bearing this in mind, and given that the provisions of the Convention are expressed in general terms, the Court often adapts its interpretation of them in the context of individual cases so as to ensure that they remain responsive to present-day conditions. The approach of interpreting the Convention in the light of evolving social realities is referred to as the principle of evolutive interpretation. This principle rests on the doctrine that the Convention is a "living instrument," whose content and meaning

[47] ECtHR, *Tysiąc v. Poland,* app. no. 5410/03, 20 March 2007.
[48] ECtHR, *Christine Goodwin v. United Kingdom*, app. no. 28957/95, 11 July 2002, § 71.
[49] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012.
[50] M. MAROCHINI, *The Interpretation of the European Convention on Human Rights*, in *Zbornik radova Pravnog fakulteta u Splitu*, 50(1), 2014, 63-68.

are not frozen at the moment of its adoption, but must be read so as to guarantee the effective protection of human rights in a changing world. By applying this doctrine, the scope and content of many rights and freedoms guaranteed by the Convention have been considerably extended.[51]

As noted above, the Court applies the "living instrument" doctrine in its case-law. An illustrative example is *Christine Goodwin v. the United Kingdom,*[52] where the Court observed that both the legal and social position of transgender persons in Europe had undergone a fundamental shift, with many Member States introducing legislation providing for legal recognition of gender reassignment. In this context, the Court stressed that maintaining its previous case-law would perpetuate solutions inconsistent with the realities of contemporary society and would obstruct the progressive development of human rights protection. Accordingly, having regard to the need to respond to changing conditions and emerging standards, the Court found that the United Kingdom, by refusing to recognise the applicant's change of gender, had violated her right to respect for private and family life as well as her right to marry.

The "living instrument" doctrine demonstrates that both evolving social conditions and legislative trends within the Member States significantly influence the Court's approach to interpretation. These developments may lead the Court to depart from its earlier case-law and to broaden the scope of individual protection. In the following section, the authors will analyse the regulatory frameworks concerning medical marijuana in Council of Europe Member States, present the results of their survey research, and attempt to assess the extent to which developments in law and public attitudes may shape the Court's jurisprudence.

According to a report by the European Monitoring Centre for Drugs and Drug Addiction,[53] legislation on marijuana across Europe is highly diverse. In some countries, consumption remains a criminal offence punishable, at least in theory, by imprisonment. This is the case, inter alia, in Cyprus, France, Finland, Greece, Hungary, Norway, Sweden, and Turkey. In practice, however, law-enforcement authorities in these States are often instructed to apply non-custodial measures, such as fines or warnings, or to exercise prosecutorial discretion to discontinue proceedings in cases of minor offences. In other States, such as Latvia, Lithuania or Portugal, possession or use of marijuana is punishable by a fine or other administrative sanction, while in Spain criminal liability arises only when consumption takes place in public. A growing number of European countries are adopting policies favouring non-custodial sanctions for individuals found in possession of small quantities of drugs, including marijuana, for personal use. In total, eleven EU Member States provide for such measures, with eight applying them to all narcotic drugs and three restricting them to marijuana alone.

The European approach to cannabis regulation has become increasingly diverse. In December 2021, Malta adopted legislation permitting limited home cultivation, possession of small amounts, private consumption, and the operation of non-commercial cannabis clubs. In July 2023, Luxembourg introduced similar measures by legalising limited home cultivation and private use. In February 2024, Germany enacted laws allowing limited home cultivation, possession, and consumption of small amounts of marijuana, as well

[51] P. ŁĄCKI, J*ustification for an Evolutive Interpretation of the Convention on the Protection of Human Rights and Fundamental Freedoms: Some Critical Questions*, in *Przegląd Sejmowy,* 2(139), 2017, 7-26.

[52] ECTHR, *Christine Goodwin v. the United Kingdom*, app. no. 28957/95, 11 July 2002.

[53] https://www.euda.europa.eu/publications/faq/cannabis-laws-europe-questions-and-answers-for-policymaking_en (last visited 10/09/2025).

as the establishment of non-commercial cannabis associations. The Czech Republic has also announced its intention to develop a regulatory framework permitting limited home cultivation and use. Outside the European Union, Switzerland has initiated pilot projects for authorised sales and alternative distribution systems targeting specific groups of residents in selected cities.[54]

Parallel to restrictions on recreational use, the medical cannabis market has been expanding in many European countries. In September 2019, the European Commission, following the assessment of the European Medicines Agency, authorised the first EU-wide cannabinoid-based product, Epidyolex, an oral solution of purified CBD, for use as adjunctive therapy in children with treatment-resistant epilepsy (Lennox–Gastaut and Dravet syndromes). Another widely used product is Sativex, an oromucosal spray containing both THC and CBD, authorised in sixteen EU countries as well as Norway and Switzerland for the treatment of spasticity associated with multiple sclerosis. Less widely available are medicinal products containing dronabinol and nabilone, primarily used as antiemetics. In some European States, treatment with medical cannabis or its derivatives is partly reimbursed under public health insurance schemes, though this is usually subject to prior administrative authorisation or a specialist's prescription.[55]

It is important to note that national cannabis regulations are increasingly shaped by EU governance mechanisms and internal market considerations, despite the absence of harmonised EU drug law. Transformations in European health governance within the EU legal order shape national frameworks particularly through European pharmaceutical law and the regulatory role of the European Medicines Agency in authorising cannabis-based medicinal products. In particular, EU soft-law instruments such as the EU Drugs Strategy 2021–2025 frame cannabis as a public health issue, promoting evidence-based regulation, harm reduction, and policy coordination across Member States.[56]

Despite an observable trend towards liberalisation of cannabis laws in Europe, the pace and scope of change vary considerably across States. In some jurisdictions, restrictive criminal provisions remain in force, although in practice custodial sentences are increasingly replaced by non-custodial measures. At the same time, more countries are adopting legislation permitting home cultivation and personal use. The medical cannabis market continues to expand. Nevertheless, it cannot yet be said that a "European consensus" exists with regard to cannabis regulation; hence, there is no basis for asserting the existence of a shared minimum standard of human rights protection among the Council of Europe Member States in this field.

Another element of importance in the context of the "living instrument" principle is public opinion on the legalisation and use of cannabis, including medical marijuana. In March 2025, the authors of this article conducted a survey entitled *Medical Use of Marijuana as an Alternative Therapeutic Measure in Poland and Europe: An Analysis of Legal Awareness, Medical Knowledge and Social Acceptance*. The study involved 115 law and medical students from Poland.

The results indicated that as many as 47% of respondents supported full legalisation of marijuana, for both medical and recreational purposes. A further 25.2% considered that marijuana should be available

[54] https://www.euda.europa.eu/publications/european-drug-report/2025/cannabis_en (last visited 10/09/2025).
[55] https://www.euda.europa.eu/publications/faq/cannabis-laws-europe-questions-and-answers-for-policymaking_en (last visited 10/09/2025).
[56] Council of the European Union, *EU Drugs Strategy 2021–2025*, Official Journal of the European Union, C 102 I/01, 2021.

exclusively for medical purposes, provided that physicians had discretion to prescribe it. By contrast, 22.6% believed that access to medical marijuana should be restricted to strictly defined medical conditions as determined by the legislature. Only 1.8% supported a total ban on both medical and recreational use.

When asked about the perceived impact of legalisation in countries that have introduced full or partial recreational legalisation, 36.6% of respondents assessed the consequences as mainly positive, 27% considered the positive and negative effects to be balanced, and 12.2% viewed them as more negative than positive. A significant proportion (23.5%) reported insufficient knowledge to express an opinion.

Respondents also identified the main risks associated with legalisation, including increased drug dependence (73.9%), higher use among minors (73%), and possible negative health effects on society (37.4%). Only 0.9% declared that they perceived no negative effects. With regard to mental health, students highlighted psychological dependence (85.2%), cognitive impairment (83.5%), risk of psychosis and schizophrenia (47%), and increased anxiety and panic (31.3%). Conversely, they pointed to positive effects such as reduction of stress and anxiety (82.6%), improved sleep quality (60%), and assistance in the treatment of depression (48.7%). 10.4% of respondents stated that they saw no positive mental health effects.

The survey demonstrates that a portion of respondents among law and medical students support legalisation of marijuana, both for recreational and medical purposes, while a slightly larger group favours access to medical marijuana on prescription, with varying degrees of discretion granted to physicians. Respondents recognised both the potential risks and benefits for mental health. The results suggest that young people tend to favour liberalisation, accompanied by appropriate regulation and education to minimise social and health risks.

At present, it is difficult to determine whether the regulatory changes among Council of Europe Member States or the growing public support for legalisation will influence the future direction of the European Court of Human Rights' jurisprudence. While the Court's use of the "living instrument" doctrine demonstrates that developments in domestic law and shifts in social attitudes can be decisive in prompting reinterpretation of the Convention and the expansion of individual protection, it remains uncertain whether this will occur in relation to the medical use of cannabis under Articles 2, 3 or 8 of the Convention.

3.3. The Margin of Appreciation

Another key interpretative principle employed by the Court in cases concerning the right to health protection is the doctrine of the margin of appreciation. This principle, sometimes referred to as the doctrine of "interpretative restraint"[57] was developed in order to leave States a certain degree of discretion in fulfilling their obligations under the Convention. It delineates the boundary between matters which may legitimately remain within the competence of domestic authorities and those which must, without exception, be guaranteed uniformly across all Contracting States.[58]

The doctrine has been applied in the Court's jurisprudence under Article 15 of the Convention, Articles 8, 9, 10 and 11, Article 2 of Protocol No. 1, as well as Article 14 of the Convention, Article 1 of Protocol No. 1, Article 6 and Article 3 of Protocol No. 1. By contrast, the rights guaranteed in Articles 2, 3 and 4 of the

[57] M. MAROCHINI, *The Interpretation of the European Convention on Human Rights*, cit., 63–84.

[58] L. GARLICKI, *Wartości lokalne a orzecznictwo ponadnarodowe – kulturowy margines oceny: w orzecznictwie strasburskim?*, in Europejski Przegląd Sądowy, 4, 2008, 4-13.

Convention are regarded as imposing absolute obligations on States, thereby excluding any scope for a margin of appreciation.[59]

The European Court of Human Rights has never provided a comprehensive definition of the margin of appreciation but has progressively developed the concept in its case-law. Its origins date back to the 1950s, when it first appeared in the report of the former European Commission of Human Rights in *Greece v. the United Kingdom* (1958),[60] concerning the compatibility of derogations with Article 15 of the Convention. The concept was then elaborated in *Lawless v. Ireland*, in which the Commission held that governments must be afforded some latitude in assessing whether a public emergency threatening the life of the nation exists,[61] The doctrine developed further in the 1970s, with a milestone judgment in *Handyside v. The United Kingdom.*[62] That case concerned the confiscation of *The Little Red Schoolbook*, classified as obscene, and allegations of a violation of Article 10 of the Convention. The Court emphasised that there was no uniform conception of morality among the Contracting States and that domestic authorities, by virtue of their direct and continuous contact with the realities of their societies, were better placed to assess the necessity of restrictions. At the same time, the Court stressed that the margin of appreciation is not unlimited, and that ultimate supervision rests with the Strasbourg organs.[63] From that judgment onwards, the doctrine became a cornerstone of the Court's jurisprudence, with the principles articulated in *Handyside* being reiterated and refined in subsequent case-law.

The doctrine of the margin of appreciation is closely linked to the principle of subsidiarity, one of the foundations of the Council of Europe's human rights protection system. According to this principle, primary responsibility for securing the rights guaranteed by the Convention lies with the Contracting States, while the Court's intervention is subsidiary and justified only where national authorities have failed to discharge their obligations. Subsidiarity, together with the doctrine of the margin of appreciation, thus delineates the division of competences between States and the Court. Their essence lies in striking a balance between respect for national sovereignty and the need for international supervision to ensure effective protection of individual rights.[64]

3.4. The Principle of Proportionality

Although not expressly mentioned in the text of the Convention, the principle of proportionality is one of the most frequently invoked interpretative principles in the Court's case-law. Already in the *Belgian*

[59] M. MAROCHINI, *The Interpretation of the European Convention on Human Rights*, cit., 63–84.
[60] ECtHR, *Greece v. The United Kingdom*, Report, No. 176/56, ECommHR, 26 September 1958.
[61] ECtHR, *Lawless v. Ireland, Report*, no. 332/57, ECommHR, 19 December 1959.
[62] ECtHR*, Handyside v. The United Kingdom*, app. no. 5493/72, 7 December 1976.
[63] A. CIŻYŃSKA-PAŁOSZ, *The Impact of the European Court of Human Rights on the Legal Order of the High Contracting Parties of the European Convention on Human Rights and the Margin of Appreciation Doctrine. Analysis with Particular Regard to the Judgment of the European Court of Human Rights in the Hirst v. United Kingdom Case*, in *Przegląd Prawno-Ekonomiczny*, 50(1), 2020, 7-28.
[64] Z. KOTUŁA, *Protokół 15 do Europejskiej Konwencji Praw Człowieka: doktryna marginesu swobody uznania i zasada subsydiarności w kontekście reformy ETPCz*, in *Studenckie Prace Prawnicze, Administratywistyczne i Ekonomiczne*, 17, 2015, cit., 85-98.

Linguistic Case[65] the Court held that the Convention requires a balance to be struck between the protection of individual rights and the demands of the general interest. Similarly, in *Soering v. the United Kingdom*[66] the Court observed that "the whole Convention is directed at maintaining a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights."[67]

The principle therefore reflects the fundamental dilemma inherent in human rights protection: reconciling the rights of the individual with the interests of the community. In practice, proportionality and the search for a fair balance function as a conflict-resolving principle, as they do not predetermine whether individual rights or the public interest should prevail, but require an assessment of their relative weight in the circumstances of each case. This is particularly significant in the interpretation of Article 8 of the Convention. In this context, the Court has repeatedly stressed that States are under both negative obligations (to refrain from arbitrary interference) and positive obligations (to take measures securing the effective enjoyment of rights). In cases such as *Rees v. the United Kingdom*[68] *and Loizidou v. Turkey,*[69] the Court emphasised that the determination of State obligations always involves striking a fair balance between the general interests of the community (such as public order, territorial integrity or the rights of others) and the individual's right to respect for private and family life. The notion of fair balance thus serves as a tool for assessing whether an interference was proportionate and whether it imposed an excessive burden on the individual.[70]

3.5. Positive Obligations of States

Given that the European Convention on Human Rights is directed at the Contracting States, it must be recognised that they have undertaken legally binding obligations arising therefrom,[71] The mere recognition of rights in the form of negative obligations – that is, obligations to refrain from unjustified interference – is manifestly insufficient. For example, in the context of the right to life guaranteed by Article 2 of the Convention, the negative obligation not to take life unlawfully does not of itself ensure adequate protection. It must be complemented by positive obligations requiring States to take appropriate measures to safeguard this right.[72]

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[65] ECtHR, *Belgian Linguistic case*, apps. nos. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 and 2126/64, 23 July 1968.

[66] ECtHR, *Soering v. the United Kingdom*, app. no. 14038/88, 7 July 1989.

[67] A. WIŚNIEWSKI, *Proporcjonalność i Fair Balance w orzecznictwie Europejskiego Trybunału Praw Człowieka*, in *Gdańskie Studia Prawnicze*, 2019, 2, cit., 214–231.

[68] ECtHR, *Rees v. the United Kingdom*, app. no. 9532/81, 17 October 1986.

[69] ECtHR, *Loizidou v. Turkey*, app. no. 15318/89, 18 December 1996.

[70] A. WIŚNIEWSKI, *Proporcjonalność i Fair Balance w orzecznictwie Europejskiego Trybunału Praw Człowieka*, cit., 214-231.

[71] M. JANKOWSKA-GILBERG, *Zakres obowiązków pozytywnych państwa na tle aktualnego orzecznictwa Europejskiego Trybunału Praw Człowieka,* in *Problemy Współczesnego Prawa Międzynarodowego, Europejskiego i Porównawczego*, VII, Special Issue – Human Rights Protection, 2009, cit., 35-48.

[72] J. CZEPEK, *Zobowiązania pozytywne państwa w sferze praw człowieka pierwszej generacji na tle Europejskiej Konwencji Praw Człowieka*, Olsztyn: Kolegium Wydawnicze UWM, 2014, cit., 14 ff.

A landmark judgment in the development of the doctrine of positive obligations is *X and Y v. the Netherlands.*[73] That case concerned a legislative requirement under Dutch law that a 16-year-old victim of sexual assault file a criminal complaint personally, which was impossible in the particular circumstances given the victim's mental disability. In examining whether there had been a violation, the Court stressed that the primary purpose of Article 8 is to protect individuals against arbitrary interference by public authorities. However, this does not mean that the right is limited to protection against State action. In certain circumstances, the right to respect for private and family life may entail positive obligations requiring the State to ensure the effective enjoyment of Convention rights in relations between individuals.

Accordingly, positive obligations of States encompass both the duty to establish an adequate legal framework enabling individuals to exercise their rights effectively and the obligation to afford protection against violations. A specific category is that of procedural obligations, which require the authorities to conduct effective investigations into alleged violations of rights and freedoms. Such procedural duties combine two types of responsibilities: States must possess appropriate legal (procedural) and practical (technical, institutional, training) mechanisms, and in any given case they must act effectively to secure the rights of the individual.[74]

Under Article 8 of the Convention, according to Professor Vladislava Stoyanova,[75] States are subject to a positive obligation to establish effective regulatory frameworks ensuring the practical and effective enjoyment of the right to respect for private and family life. Unlike negative obligations, failures engaging Article 8 of the Convention often arise from omissions, including the absence or inadequacy of domestic regulation. Such omissions cannot be assessed solely by reference to domestic legality, as the alleged breach may consist precisely in the lack of a clear legal framework. While States enjoy discretion as to the form and means of regulation, obligations arising from Article 8 of the Convention are not fulfilled unless a legal framework is in place that adequately balances the competing interests at stake and provides minimum safeguards against arbitrary interference. The existence of regulation alone is insufficient – what is decisive is whether the framework, taken together with its implementation, effectively secures respect for private life in practice.

4. Analysis of the Case-Law of the European Court of Human Rights Concerning the Right to the Protection of Health and the Application of Unconventional Therapeutic Measures

The issue of the application of unconventional therapeutic measures constitutes one of the more complex and controversial areas of reflection in the case-law of the European Court of Human Rights. The bioethical dialogue concerning the legitimacy of their widespread use in the therapeutic process, most frequently in the character of agents with analgesic effects, assumes a twofold nature – ranging from the individual rights of the suffering person to the social harmfulness connected with the possible abuse of a psychotropic substance. At the centre of these considerations, there invariably remains the inherent and

[73] ECtHR, *X and Y v. The Netherlands,* app. no. 8978/80, 26 September 1985.

[74] M. JANKOWSKA-GILBERG, *Zakres obowiązków pozytywnych państwa na tle aktualnego orzecznictwa Europejskiego Trybunału Praw Człowieka*, cit., 35-48.

[75] V. STOJANOVA, *Positive obligations under the European Convention on Human Rights: within and beyond boundaries*, Oxford, 2023, cit., 171-175.

inalienable dignity of the human person, which constitutes the essence of all rights and freedoms guaranteed to man by the very fact of being human.
In this part of the study, three judgments of the Court hitherto delivered, directly touching upon the matter of the use of marijuana by individual persons in the character of an antinociceptive measure, shall be subjected to analysis. Against their background, the Court undertook an attempt at an appropriate balancing conflict interest – the individual autonomy of the suffering person and the entitlement of the State to interfere in this sphere for the purpose of protecting public health, as well as preventing potential threats resulting from the use of psychoactive substances. Subsequently, having regard to the scant number of judgments of the Court directly referring to the issue under analysis, the intention of the authors is to deepen its examination, by referring to the Court's jurisprudence thus far, in particular to the judgments delivered within the border bioethical discourse.

4.1. Analysis of the *A.M. and A.K. v. Hungary* Case

In the Court's jurisprudence, the issue of the use of marijuana for therapeutic purposes appeared for the first time in the case of *A.M. and A.K. v. Hungary*.[76] In the present case, the applicants, suffering respectively from multiple sclerosis and systemic sclerosis, claimed the possibility of using medical cannabis, indicating that the statutory prohibition of the medical use of cannabis-based medication directly violates their right to privacy, including the right to decide about their own health and the manner of treatment.[77] They submitted that the then-existing legal framework in Hungary regarding the application for cannabis-based medicinal products – consisting in the necessity of obtaining an individual authorisation form the institute for the importation of the medicine on the basis of a medical prescription – lacked sufficient legal certainty, causing a so-called chilling effect among practising doctors.[78] In the applicant's view, the absence of clear and unambiguous legal regulations in this field deprived them of actual access to an effective therapeutic alternative and, consequently, led to weaker protection of their health in comparison with patients from other European and global jurisdictions.
In the present case, the Court declared the application manifestly ill-founded, finding no violation of the rights and freedoms of individuals failing within the normative scope of Article 8 of the Convention.[79] With regard to the issue of the medical use of marijuana in pain-relief therapy, the Court emphasised that it is not its role to determine the choice of the best method of treatment in a given situation. Proceeding further, it indicated that the assessment of the appropriateness of the use of specific medicines – including those based on cannabis – by patient should be made by the treating physician, and not result from general research of the applicant's subjective conviction that a given preparation could alleviate their pain symptoms.[80] At the same time, the applicants did not demonstrate that the issue of treatment with cannabis had been the subject of a broader discussion with their treating physicians, nor that they had ever been refused access to such a method of treatment.[81]

[76] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017.
[77] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 18.
[78] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 20.
[79] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 53.
[80] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 49.
[81] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 50.

The Court carried out a broader analysis of the applicants' principal allegation concerning the domestic provisions regulating the availability of cannabis for medical purposes. In this regard, the Court observed that it is the duty of the State to ensure clear accessible and foreseeable regulations, so that citizens as well as doctors may act without fear of criminal sanctions.[82] In view of the foregoing, the European Court of Human Rights aligned itself with the government's position, expressly stating that Hungarian law in fact did not create a genuine chilling effect, and that the applicants had not demonstrated the practical unavailability of alternative solutions, since they themselves ultimately did not resort to them.[83] At the same time, it emphasised the wide margin of appreciation enjoyed by States in the sphere of health policy conducted by them – including that concerning medical marijuana – particularly where there is no European consensus as to scope of its legislation.[84]

In the authors' assessment, the foreign consideration of the Court requires supplementation with a broader context, referring in this respect to the substantive assumptions adopted in its landmark judgment in *Tysiąc v. Poland*.[85] In the case at hand, albeit concerning a wholly different bioethical dilemma - namely the right to therapeutic abortion – the Court pointed to the essence of one of the most important interpretative principles underlying the Convention, namely the effectiveness of the rights and freedoms protected thereby.[86] Although, in the light of the Court's current jurisprudence, it cannot be maintained that an individual has been granted a subjective right to pursue self-therapy through arbitrarily chosen substances, particularly those with psychoactive intensity, nonetheless, where the law of a given State provides for the possibility of applying for such substances through defined procedure, such procedure ought to be effective, transparent and free from risk of arbitrariness on the part of the public authorities.[87] In view of the above, when assessing the effectiveness of the realisation of the right to respect for family life, the Court should examine whether the applicable legal framework concerning the application for cannabis-based medicine is not of a blanket nature, which in practice would lead to a de facto restriction of that right.

4.2. Analysis of the *Thörn v. Sweden* Case

In the case of *Thörn v. Sweden*,[88] the Court, for the first time, attempted to balance the values protected under Article 8 of the Convention with the need to ensure adequate protection of the public interest in the field of national anti-narcotics policy. The applicant, having suffered a broken neck as a result of a car accident, endured chronic pain and muscle spasm caused by his injuries, which significantly impeded his daily functioning. He consistently sought to alleviate his pain by making use of various means and therapies with antinociceptive effects, including a cannabinoid-based medicine – Sativex – the purchase of which generated high costs for the applicant. All therapeutic methods undertaken thus so far failed to produce tangible results, condemning the applicant to continued physician and psychological duress. In the light of the foregoing, after acquainting himself with information available on the Internet concerning

[82] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 46.
[83] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 50.
[84] ECtHR, *A.M. and A.K. v. Hungary*, app. nos. 21320/15 and 35837/15, 4 April 2017, § 31.
[85] ECtHR, *Tysiąc v. Poland*, app. no. 5410/03, 20 March 2007.
[86] ECtHR, *Tysiąc v. Poland*, app. no. 5410/03, 20 March 2007, § 113.
[87] ECtHR, *Tysiąc v. Poland*, app. no. 5410/03, 20 March 2007, §§ 112-113.
[88] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022.

the heath-promoting properties of cannabis, he decided to cultivate this plant himself for therapeutic purposes. Upon commencing the use of cannabis by the applicant, a significant improvement in his quality of life was observed – encompassing both his return to full-time professional activity and a substantial enhancement of his family relationships.[89]

As a consequence of these actions, the applicant was charged with two criminal offences: the offence of production and possession of narcotic substances, and the lesser offence consisting of the consumption of such substances.[90] In the course of the domestic proceedings, the case was ultimately referred to the Supreme Court of Sweden, which eventually found the applicant guilty of the production of narcotic substances, imposing upon him a fine in the total amount of EUR 520.[91]

At this juncture, particular attention should be drawn to the reasoning of the Supreme Court in the present case, which proved decisive for the Court's final determination.[92] In conducting meticulous deliberations on the issue of whether the applicant should be exempted with criminal liability, the Supreme Court examined whether, under domestic regulations, he acted in a state of necessity.[93] The Supreme Court, however, concluded that Swedish law did not provide a basis for a complete exemption from criminal liability for the offences charged, nonetheless simultaneously taking into account the applicant's motivation in committing the offence. It found it understandable that "the applicant had given priority to his legitimate interest in freedom from pain over society's interest in the control of narcotics".[94] The Swedish Court emphasised that the pain and suffering with which the applicant was constantly struggling, together with the relatively low risk of harm to third parties resulting from the cannabis in his possession – which contained only a low concentration of active substances – warranted consideration in sentencing, which ought to be set well below the statutory minimum custodial sentence.[95]

In the light of circumstances outlined above, the applicant alleged that Sweden had violated his rights and freedoms protected under Article 8 of the Convention, pointing to the necessity of assessing whether his conviction has preserved a fair balance between individual interest in living free from pain and the pressing social need for drug control.[96] In this context, he argued that the margin of appreciation to be afforded to the State in the present case ought to be as narrow as possible, stressing that the matter concerned solely his individual punishment and not broader questions relating to drug-control policy[97]. In response to this position, the respondent acknowledged that there had indeed been an interference with the applicant's rights falling within the sphere of his autonomy and the protection of his psychological and physical integrity. Nevertheless, they maintained that such interference was justified by the overriding public interest at stake. In this regard, it was pointed out that Sweden had ratified the United Nations Single Convention on Narcotic Drugs and was accordingly subject to the obligations arising therefrom.

[89] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, §§ 2-7.
[90] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 8.
[91] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 32.
[92] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, §§ 12-32.
[93] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 13
[94] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 19.
[95] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, §§ 25-27.
[96] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 39.
[97] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 40.

Furthermore, they emphasised that the present case did not concern medical cannabis, but rather the unlicensed cultivation of cannabis for self-medication, entirely outside the supervision of the national authorities.[98]

In addressing the present case, the Court began by recalling that the right to health as such does not fall within the catalogue of rights guaranteed under the Convention – accordingly, there was a need to approach the issue raised indirectly, through the prism of other Convention provisions.[99] In this regard, it pointed out that matters of this kind, situated within the spectrum of broadly understood personal autonomy and quality of life of a person, may fall within the protection of private life. At the same time, it stressed the significant importance of an individual's bodily integrity in the face of pain, as belonging to one of the most intimate spheres of human existence. Finally, it reiterated the wide margin of appreciation enjoyed by States in the shaping of health policy, particularly where a given case raises sensitive moral or ethical questions.[100]

In the subsequent part of its judgment, the Court found that it was undisputed between the parties that there had been an interference with the applicant's rights and freedoms under Article 8 of the Convention, while also noting that the State's actions were in accordance with the law and pursued a legitimate aim.[101] It therefore proceeded to examine the necessity of interference in a democratic society. In this respect, it referred primarily to the reasoning of the Supreme Court of Sweden, recalling that, under Swedish law the applicant's situation and the circumstances in which he had found himself did not constitute a ground of justification in the form of necessity.[102] Moreover, the Court endorsed the respondent's position that the severity of the sanction imposed on the applicant was relatively low, as the domestic court had taken account of his personal situation and the factual circumstances which had led him to commit the offence.[103]

In the present case, when addressing the broader debate concerning the availability of cannabis for therapeutic purposes, the Court observed that, in fact, the case before it was not concerned with whether a prohibition on the production or consumption of cannabis – whether for medical or recreational purposes – is in itself incompatible with the right to respect for private life.[104] Rather, the central issue under consideration was whether the domestic authorities had violated the applicant's right to respect for his private life by failing to exempt him from the general criminal liability normally attaching to the unauthorised consumption and production of prohibited substances. Consequently, the Court did not engage in any in-depth in abstracto analysis in this respect, limiting itself to the finding that, in view of the factual circumstances presented, there had been no violation of the applicant's right to respect for his private life, as the domestic courts had appropriately balanced the competing legal interests at stake in the case. In its concluding observations, the Court further underlined that the starting point for determining whether a violation of the applicant's rights had occurred was not an assessment of whether the State could have adopted a different, less restrictive policy in this field. Rather, it was whether, in weighing the applicant's

[98] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 44.
[99] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 46.
[100] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 46.
[101] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 49.
[102] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, §§ 51-53.
[103] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 57.
[104] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 55.

interest in obtaining relief from pain against the general interest in enforcing the system of drug and medicine control, the State had remained within the bounds of its wide margin of appreciation.[105]

4.3. Analysis of the *Hristozov and Others v. Bulgaria* case

Another case concerning the reconstruction of the right to the protection of health under the Convention examined by the Court is *Hristozov and Others v. Bulgaria*.[106] Although the case dealt with the refusal to authorise the use of an experimental anti-cancer drug in Bulgaria, and did not concern, unlike *Thörn v. Sweden* or *A.M. and A.K. v. Hungary*, the use of cannabis for therapeutic purposes, the conclusions drawn by the Court appear particularly significant in the context of the "compassionate use of medicines" procedure and the related necessity of balancing competing interests, namely the personal autonomy of the individual and the protection of public health and safety.

The applicants in *Hristozov and Others* were terminally ill cancer patients who had already undergone a number of conventional treatments (including surgery, chemotherapy, radiotherapy and hormone therapy), or who had received medical opinions that such therapies would not be effective in their particular cases, or were not available in Bulgaria. They nevertheless obtained information about an experimental product developed by a Canadian pharmaceutical company. The product had not been authorised anywhere in the world and had not completed full clinical trials, but several States had allowed its administration under a "compassionate use" exception".[107] "Compassionate use" can be defined as the possibility of granting access to a medicinal product which has not yet received marketing authorisation, for patients suffering from a serious, chronic or life-threatening disease, provided that the product is undergoing clinical trials or a registration procedure. The rationale for this mechanism lies in the lack of satisfactory treatment options with already authorised products. The purpose of the "compassionate use" exception is to provide access to potentially beneficial therapies when conventional methods have failed, proved inadequate or are unavailable, under the assumption that the expected therapeutic benefits outweigh potential risks for the patient, and that such use will not interfere with ongoing clinical trials or regulatory procedures.[108] Although the applicants sought access to the drug, it was denied.[109]

They argued that the refusal to grant them access to the experimental treatment through the "compassionate use" mechanism violated their rights under Articles 2, 3 and 8 of the Convention. In their view, the State had failed to take adequate steps to protect the lives of individuals within its jurisdiction. The regulatory framework governing "compassionate use" was insufficient, as it did not allow for consideration of the applicants' individual circumstances.[110] They further submitted that the State had effectively forced them to await death despite knowledge of an experimental product which might have improved their condition and prolonged their lives.[111] In particular, they claimed that the refusal amounted to a

[105] ECtHR, *Thörn v. Sweden*, app. no. 24547/18, 1 September 2022, § 59.
[106] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012.
[107] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 9.
[108] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, §§ 50, 56-57.
[109] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 14.
[110] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 100.
[111] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 102.

violation of their right to respect for private life under Article 8, by depriving them of the opportunity to attempt to extend their lives and avert death.[112]

The Government, for its part, maintained that the products in question carried serious risks and required strict regulation.[113] While acknowledging that there had been an interference with the applicants' rights under Article 8, the Government argued that the interference was lawful, pursued the legitimate aim of protecting health and was necessary in a democratic society. It responded to the imperative of striking a fair balance between public interest and individual autonomy, with a view to safeguarding public health and protecting society against the risks inherent in the use of untested products.[114]

The Court was therefore faced with the need to assess whether, in circumstances where an individual suffers from a terminal illness and experimental treatment appears to be the only option, the right to personal autonomy - including the avoidance of suffering and the prolongation of life - should prevail, or whether priority should instead be given to the State's duty to protect its citizens and ensure safety from potentially harmful substances. At the outset, however, the Court noted that the Convention does not impose on States an obligation to provide a specific level of access to unauthorised medicinal products for terminally ill patients.[115] Issues of health policy generally fall within the margin of appreciation of the national authorities, who are best placed to assess priorities, resource allocation and social needs.[116] Moreover, in the Court's assessment, the refusals in question had not reached the requisite threshold of severity to constitute inhuman treatment.[117]

In evaluating the applicants' complaints, the Court emphasised the need to conduct a proportionality assessment between the individual interest and that of society as a whole, taking into account the margin of appreciation afforded to the State in this sphere.[118] While the Court recognised that the applicants' interest in accessing treatment capable of alleviating or combating cancer was of the utmost importance, it also underscored that the quality, efficacy and safety of the experimental products in question remained uncertain.[119]

Furthermore, the Court concluded that the public interest in regulating access to experimental products for terminally ill patients lay primarily in protecting those patients against potential threats to their health and life where all the risks and benefits were not yet known. Furthermore, it observed that this public interest also encompassed the development of new medicines, inter alia through enabling patients to participate in clinical trials. All these objectives, closely linked to the rights guaranteed under Articles 2, 3 and 8, required the striking of a delicate balance involving complex ethical considerations and risk assessment, particularly in the context of rapid advances in medicine and science.[120] The State's margin of appreciation in weighing these competing interests had therefore to be a wide one.[121]

[112] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 104.
[113] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 99.
[114] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 103.
[115] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 108.
[116] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 119.
[117] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 113.
[118] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 117.
[119] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 120.
[120] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 122.
[121] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 124.

Given the breadth of that margin in this field, the Court held that the Bulgarian regulatory framework underlying the refusal to authorise the use of the experimental drug had not breached Article 8 of the Convention. The solution, which tilted the balance decisively in favour of safety considerations while not entirely excluding access to unauthorised products, was deemed fair and consistent with the requirements of the Convention.[122]

It has however been observed in the dissenting opinion of judge De Gaetano joined by judge Vucinić[123] that the approach adopted by the Bulgarian authorities in *Hristozov and Others v. Bulgaria* may be perceived as particularly restrictive. The domestic authorities gave no weight to the interest of terminally ill patients by refusing the applicants any form of access to experimental treatment. The patients did not have the opportunity to attempt therapies that, despite entailing heightened uncertainty as to their safety and efficacy, may constitute their sole remaining chance to preserve life or slow the progression of an otherwise fatal disease.

On the other hand, confirmation of the Court's approach concerning access to unauthorised methods of treatment may be found in *Durisotto v. Italy*.[124] The applicant, the father of a severely ill child, alleged a violation of Article 8 on account of the refusal to grant his daughter access to an experimental therapy known as the "Stamina method." He argued that by denying this form of treatment, the State had interfered with his right to respect for family life and to decide upon the medical treatment of his own child.

The Court declared the application inadmissible. It reiterated the wide margin of appreciation enjoyed by States in the field of health policy and in protecting patients against alternative therapies. It noted the absence of a European consensus on such treatment methods, as well as the lack of evidence of their effectiveness, concluding that States remain free to decide autonomously whether to authorise them. In this sense, *Durisotto* confirmed the Court's case-law indicating restraint in developing substantive standards of patient protection in contested areas.

5. Conclusions

The considerations presented above show that the issue of medical cannabis in the context of the European Convention on Human Rights is neither marginal nor simple. On the contrary, it reveals a whole range of tensions between individual autonomy and the State's obligation to shape health policy and protect the public interest.

As can be seen from the judgments described in this part of the article, the Court accepts that the decision to undergo treatment falls within the scope of private life and is therefore part of the individual's freedom to decide about their own body and health. However, this right is not absolute. The Court resolves the conflict between individual autonomy and social harm primarily by applying a proportionality test, examining whether the interference with the patient's autonomy is provided for by law, whether it pursues a legitimate aim of protecting health and safety, and whether it is necessary in a democratic society, which means that the State has not exceeded the limits of its margin of appreciation. In practice, when ruling

[122] ECtHR, *Hristozov and others v. Bulgaria*, app. nos. 47039/11 and 358/12, 13 November 2012, § 125-126.
[123] ECtHR, Dissenting Opinion of Judge De Gaetano joined by Judge Vučinić, *Hristozov and others v. Bulgaria,*, app. nos. 47039/11 and 358/12, 13 November 2012, § 4-7.
[124] ECtHR, *Durisotto v. Italy*, app. no. 62804/13, 28 January 2016.

against the applicants, the Court relies on two main arguments: the lack of a European consensus on the effectiveness and safety of the therapy, which broadens the margin of appreciation of the State, and the protection of patients from the risks associated with the use of unauthorised substances.

An analysis of the above ECtHR case law reveals a certain pattern: although the Court recognises that the choice of treatment falls within the scope of the right to privacy, in practice it often gives priority to the protection of public health and the need to prevent the risks associated with therapies of uncertain effectiveness. The margin of appreciation granted to States in these matters remains wide, and the lack of a European consensus further strengthens their regulatory freedom.

The case law of the European Court of Human Rights reveals that the Convention does not explicitly guarantee the right to health protection, but this right is reconstructed through other provisions, namely Articles 2, 3 and, above all, Article 8 of the Convention.[125] The right to life provides the basis for assessing whether State negligence leads to a real threat to the existence of the individual. The prohibition of torture and inhuman treatment sets a limit on suffering that the State cannot ignore. The right to respect for private and family life, on the other hand, becomes a fundamental point of reference for discussions about the patient's right to decide about their health and treatment. In practice, it is Article 8 of the Convention that opens up space for consideration of medical cannabis, as it covers such important values as individual autonomy, physical and mental integrity, and the right to informed consent to treatment.

At the same time, an analysis of Strasbourg cases shows the Court's restraint. In most cases, the ECtHR leaves State a wide margin of appreciation, emphasising the lack of a European consensus on cannabis regulation. The lack of a uniform standard means that the Court avoids creating new substantive obligations, limiting itself to reviewing the proportionality of States' actions and examining whether regulations are consistent, predictable and do not lead to arbitrary restrictions on individual rights. This approach is understandable in light of the principle of subsidiarity, but it raises the question of whether it leads to a situation where patient protection becomes overly formal and not real.

It is worth noting that in its case law on medical cannabis, the Court does not deny the importance of an individual's right to relief from suffering or their autonomy. On the contrary, it recognises that the choice of treatment is a matter of private life and that the decision to use alternative therapies is legally protected. However, when the interests of the individual clash with the public interest, understood as the need to control psychoactive substances or regulatory caution towards experimental therapies, State policy takes precedence. This means that patients who do not find effective help within standard therapies face a barrier that the Court is not willing to break at this stage.

Nevertheless, it cannot be ignored that the situation surrounding medical cannabis is changing rapidly. More and more European countries are deciding to liberalise regulations and create controlled systems for access to cannabinoid therapies. At the same time, social acceptance of the use of cannabis for medical purposes is growing, as confirmed by both public opinion polls and legislative practice. If we consistently apply the principle of a 'living instrument', according to which the interpretation of the Convention should evolve in line with social and scientific changes, it is difficult to imagine that the Court could completely ignore these processes in the future.

It seems that the direction in which the ECtHR should be heading is not towards the general legalisation of medical cannabis, but towards setting minimum standards for patient protection. These standards

[125] W. SCHABAS, *The European Convention on Human Rights: A Commentary*, cit., 372.

should be based on the positive obligations of States – the creation of transparent and realistic procedures for access to treatment in situations where traditional methods of treatment fail. It is to be expected that the Court will increasingly emphasise the obligation of States to provide patients with not only a formal but also a practical path to effective treatment. Protection from criminalisation in situations of 'medical necessity' should be recognised as part of a proportionate health policy, rather than an expression of excessive leniency towards the law. Finally, with the development of scientific knowledge and growing European consensus, the margin of appreciation of States in regulating cannabis should gradually decrease.

Ultimately, the conclusions drawn from the analysis seem clear: health protection under the Convention cannot remain a purely abstract category, and the right to private life cannot be interpreted in a way that reduces it to a mere formal guarantee. If patient autonomy and the right to a dignified life are to be real, the Court should make it increasingly clear that States cannot hide behind the argument of regulatory caution when in practice it leads to condemning people to suffering. Subsidiarity and margin of appreciation cannot become an excuse for a lack of responsibility for the fate of individuals.

Ultimately, the desired direction is an interpretation of the Convention that preserves States' right to shape health policy but sets a clear limit: patient suffering that can be alleviated by available means cannot be ignored in the name of an abstract public interest. The Court should thus establish a future standard of balance – one that respects State sovereignty and regulatory responsibility while guaranteeing patients a real right to relief from suffering.