International Journal of Vaccine Theory, Practice, and Research

IJVTPR

A Peer-Review of the Vaccinated vs. Unvaccinated Study Discussed at the Senate Hearing on September 9, 2025 [1]

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Abstract

The study by Lamerato et al. (2020-2025) is one of the most comprehensive real-world demonstrations ever conducted showing a dramatic increase in chronic illness attributable to compliance with the CDC childhood vaccine schedule. That list of shots was still growing during the time the study in question was conducted and as of the time of this writing now "recommends" 81 quasi-mandated doses of vaccines between birth and age 18 plus various additional ones. Between 2020 and 2022, at the Henry Ford Health System in Detroit, Lois Lamerato, PhD, Abigail Chatfield, MS, Amy Tang, PhD, and Marcus Zervos, MD — the latter being the researcher who had helped solve the water problem in Flint, Michigan — found that exposure to one or more vaccines was associated at a bare minimum with *at least* "an overall 2.5-fold increase in the likelihood of developing a chronic health condition" (p. 1). The unvaccinated cohort of 1,957 individuals received no doses of the vaccines on the CDC schedule whereas the median number of vaccinations received by the 16,511 individuals in the vaccinated cohort was 18. The original report — though not peer-reviewed until here and now — is in the public record of the US Senate Hearing on September 9, 2025 conducted by Senator Ron Johnson of Wisconsin. Our deeper look at the data shows that for symptoms characteristic of neuropathies in the autism spectrum, there is a 5.491-fold increase in the vaccinated cohort. Of the 22 chronic disease conditions studied, proportional contrasts always favor the unvaccinated. The most dramatic contrasts occurred in asthma, autism, auto-immunity, ADHD, brain dysfunction, mental health disorders, behavioral disability, developmental delay, learning disability, intellectual disability, speech disorder, motor disability, tics, other disability disorder, neurological disorder, and seizure disorder. At ten years of follow-up, 57% of the vaccinated cohort had at least one chronic disorder, compared with 17% in the unvaccinated.

Keywords: *adverse events, autism, auto-immunity, ADHD, brain dysfunction, chronic health conditions, COVID-19 vaccination, epilepsy, mental health disorder, behavioral disability, developmental delay, learning disability, intellectual disability, speech disorder, motor disability, neurological disorder, seizures, tics, vaccinated versus unvaccinated*

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[1] Lamerato et al. (2020-2025) is peer-reviewed here by Oller, Broudy, and Hulscher, but was also reviewed by other members of the *IJVTPR* Editorial Board named in the **Acknowledgments**. The original work by Lamerato et al. is liberally quoted under "fair use law". Lamerato et al. were invited to submit their original work for peer-review. They did not do so. Now they are invited to respond, if willing to submit their response to peer-review, to this commentary.

Introduction

This review article focuses on the disastrous outcomes of childhood vaccines as documented in the landmark study by Lamerato, Chatfield, Tang, and Zervos (2020-2025). The effort undertaken by those authors was, in our view, courageous. As noted in the documentary film by Del Bigtree (2025), the comparison of vaccinated and unvaccinated cohorts at the Henry Ford Health Center in Detroit was undertaken by proponents of the CDC childhood vaccine schedule to forever silence the people who doubt the claims that vaccines are "safe and effective", "save millions of lives every year", and so forth. As Aaron Siri explained at the Senate Hearing on September 9, 2025 — and as he elaborates in his book, *Vaccines, Amen! The Religion of Vaccines* (2025) — the authors of the study in question were very much in the "I-believe-in-vaccines!" congregation before they undertook the study. By contrast, a growing number of parents with children afflicted by the growing epidemic of chronic disease conditions (F. Kennedy et al., 2025) including the vast majority of the chronic diseases studied by Lamerato et al., although they used to belong to the supporters of childhood vaccines, have increasingly come to doubt the mainstream narrative.

As Siri points out in his book about the vaccine religion, none of the prior backsliders from that religious faith seem to have ever thought to ask why the US Congress found it necessary in 1986 to make vaccine manufacturers immune to lawsuits brought by the parents, guardians, or other responsible citizens on behalf of persons injured by vaccines. While independent researchers including a team headed up by the lead author of this paper — see Oller et al. (2010-2025, pp. 631-639) — had pointed out the fact that the National Childhood Vaccine Injury Act of 1986 "was designed first and foremost to protect the manufacturers of vaccines, and the government agencies that promote their use from suits filed in civil courts by individual citizens" (p. 637), no one, to our knowledge, until Siri came along, had thought to ask why vaccines are the only products in all the world that need this kind of government shielding. It cannot be on account of their being completely "safe and effective". Products that have those characteristics don't need government protection.

Even though the findings of Lamerato et al. showed that the conformity of parents to the vaccine schedule amounts, in fact, to a looming health disaster for their children — under pressure from the joint vested interests at the Henry Ford Health Center and Wayne State University where Zervos and the others are employed (see the documentary film by Bigtree, 2025) — the authors, as we will show here, would continue to express support for the vaccines included in the US Centers for Disease Control and Prevention (CDC) Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger. As we show in the rightmost column of Figure 1, that schedule accounts for at least 81 "recommended" doses of various vaccines plus an indeterminate number of doses of several vaccines that have not yet been added to the quasi-mandated plan. That complex schedule is elaborated in a detailed 15-page document with multiple hyperlinks to other webpages.

Though it is the main federal agency supposed to be guarding the health of the US population, the CDC, as well as the other watchdog agency, the Food and Drug Administration (FDA), has increasingly come under critical public scrutiny on account of them both having been captured by the pharmaceutical industry — especially the vaccine manufacturers — the very entities they are supposed to be overseeing (Alster, 2016; Childrens Health Defense, 2021; Jacobs, 2021; Prasad, 2022). In addition to empirical determination of the causes of autism and other chronic disease conditions, the task for pathologists, toxicologists, and researchers is made more complex by the propaganda "culture influenced on nearly every front by powerful forces" — the pharmaceutical

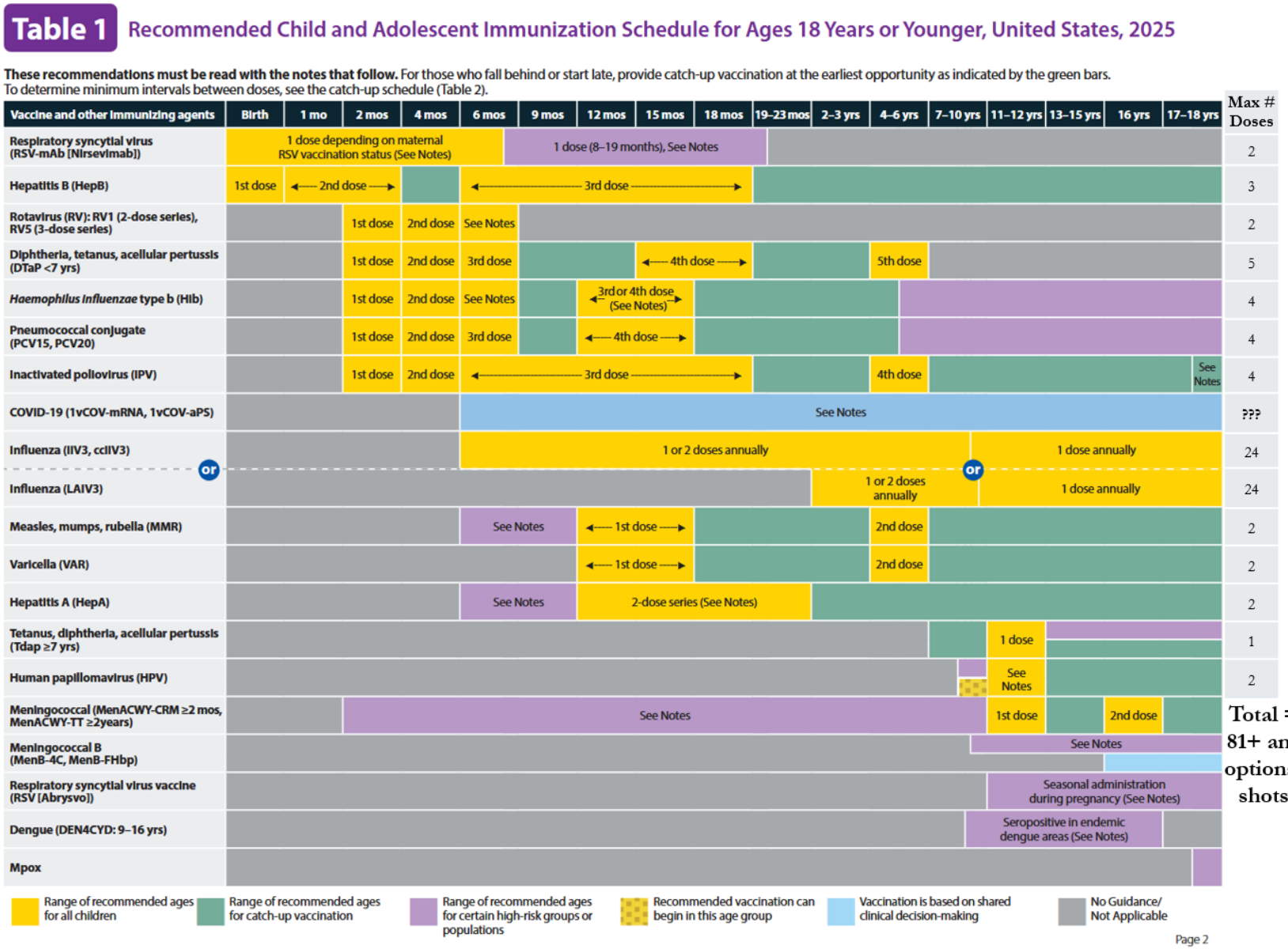


Figure 1. At the right-hand side of the self-explanatory table in gray boxes we give the maximum number of doses on each row if all the recommended shots are taken. There are 81 but this number would be increased if any optional shots are included. Downloaded at https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf on 05 November 2025. Used under "fair use law". [it would help to clarify that this table is from them, used as a figure by the authors of this article]

giants, governments, technocrats (see R. F. Kennedy, Jr. & Planet Humans, 2020) and other non-state players seeking to maintain the momentum of the vaccine industry (Broudy, 2022). As Siri (2025) has argued, it seems that the propaganda about vaccines has achieved the status of an unassailable belief-system with many people in the medical profession, the pharmacies, hospitals, patients, and the captured oversight agencies to such an extreme that those inside the belief-system cannot even be rationally influenced by empirical evidence. Or, perhaps if they are influenced, they may be silenced in a large part for fear of losing their livelihood (see comments by Zervos at the end of the documentary film produced by Bigtree, 2025a) because of potential retaliatory action by the pharmaceutical industry that controls the mainstream narrative (Broudy & Arakaki, 2020; Children's

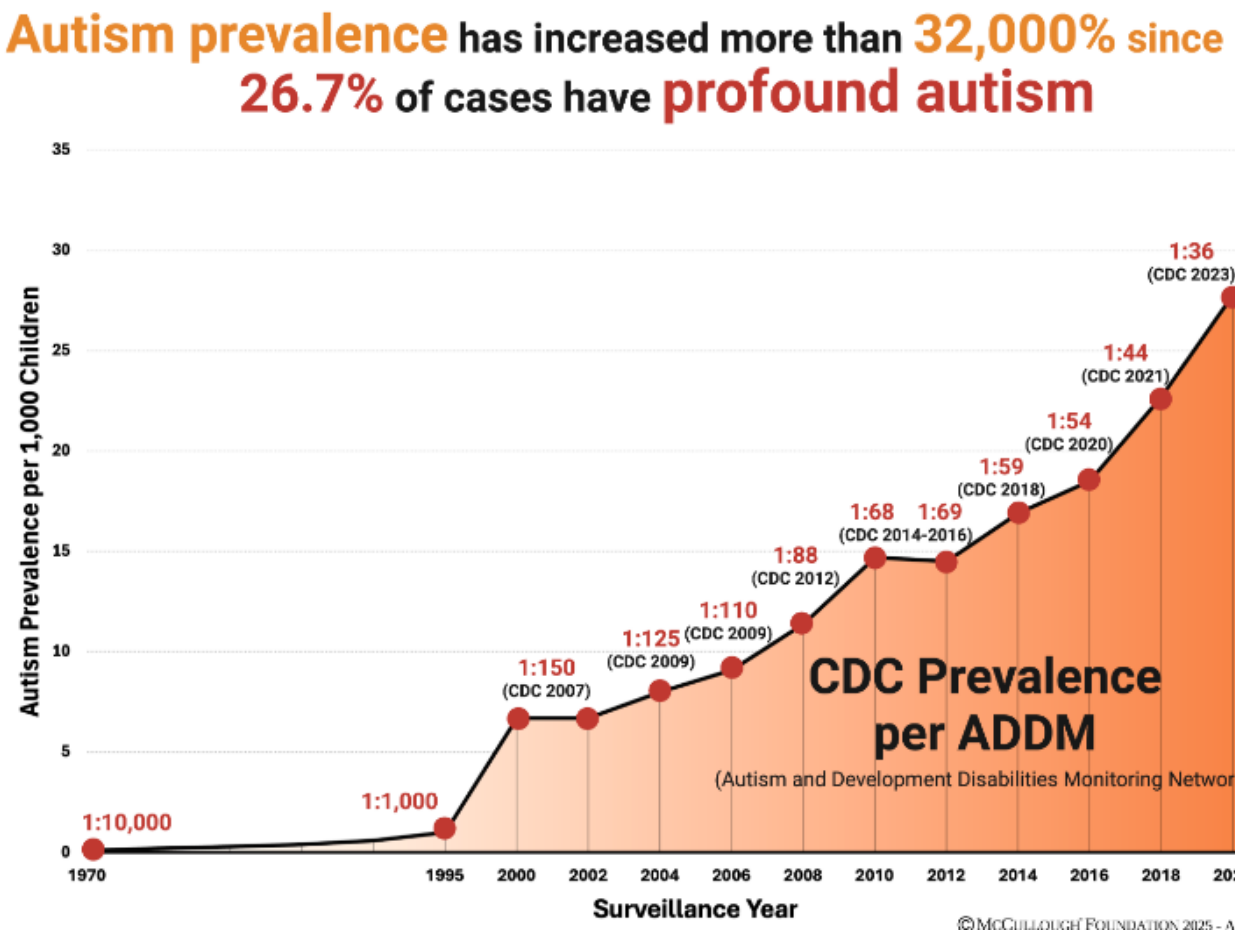


Figure 2. Autism prevalence has kept up with increases in the number of childhood vaccinations. This chart — copyright © McCullough Foundation 2025, all rights reserved — is reprinted with permission: Hulscher, N., Leake, J. S., Troupe, S., Rogers, C., Kirstin Cosgrove, Mead, M. N., Craven, B., Radetich, M., Wakefield, A., & McCullough, P. A. (2025). *McCullough Foundation Report: Determinants of autism spectrum disorder*. Zenodo. Figure 1, page 9. https://doi.org/10.5281/zenodo.17451259

Health Defense, 2021; Broudy, 2021, 2025).

Doubts about Discrete Toxicants Shift to the CDC Schedule

The surveillance numbers through 2022, summed up in Figure 2, emphatically confirm growth trends in chronic childhood diseases that were just beginning to be detected 50 years ago. Concerns

about particular, discrete toxic ingredients such as formaldehyde (Gottshall et al., 1975), the ethyl mercury in thimerosal (Gupta et al., 1987; Wakefield, 1998; Verstraeten et al., 1999; Cave, 2001; Verstraeten et al., 2003; Robert F. Kennedy, Jr., 2014), and later aluminum adjuvants (Latin for "helpers") to shock the body's immune defenses into high gear (Offit & Jew, 2003; Wakefield & Maurer, 2005; Tomljenovic & Shaw, 2011; Shaw et al., 2014), as well as disease agents such as the measles virus (Wakefield, 1998; Wakefield, et al., 1998; Kawashima et al., 2000) were among the first to be spot-lighted as possible causal factors in the growing, and later undeniable, autism epidemic (Oller, Oller, & Wakefield, 2010). From about 2010, however, the focus of attention shifted from particular discrete ingredients of specific injectables to the entire CDC vaccine schedule itself (Oller et al., 2010, 2025; Oller, Oller, & Wakefield, 2010; Olmsted et al., 2011; Tomljenovic & Shaw, 2011; Wakefield & McCarthy, 2011; Kern et al., 2012; Seneff et al., 2012; Shaw et al., 2014; Gale & Null, 2017; Nevison et al., 2018; Caceres, 2019; Lyons-Weiler et al., 2021; Garner, 2022; Bjelogrlic, 2025).

Over the years, the prevalence of the autism diagnosis has continued to increase, as documented in Figure 2, and as argued by the McCullough Foundation researchers to be a consequence primarily of the CDC childhood vaccine schedule (Hulscher et al., 2025). The Lamerato et al. study (2020-2025), we believe, merits special attention in relation to that still on-going discussion. In the CDC childhood vaccination schedule, the fulcrum of the whole system is the colorful roadmap for pediatricians that we reproduced and amplified in our Figure 1. There, all the recommended (quasi-mandated) vaccines for children from birth to age 18 are featured. As we have already noted, the plan laid out there is supplemented for adolescents, and adults in the 15-page series recommending additional vaccines with many hyperlinks to other webpages. The "childhood" schedule by itself, however, as shown in Figure 1 in the rightmost column (one that we have added to the CDC figure) leads through a maximum of 81 doses of vaccine urged upon parents by their pediatricians at what are called "well visits" — actually, doctor visits planned for the main purpose of promoting the vaccines.

As is well-known from various analytical procedures performed by independent researchers, the "childhood vaccines" in particular — along with various other vaccines that the CDC has added for adolescents, adults, and pregnant women — without exception contain a multitude of undeclared contaminants (Shaw et al., 2014; Gatti & Montanari, 2016; Donolato, 2018; Diblasi et al., 2024; Kaiser et al., 2025; Speicher et al., 2025). The present schedule for the "childhood vaccines" which is the money machine at the center of the pharmaceutical industry is, in fact, practically mandated as it has been and is being interpreted by the vast majority of pediatricians. To top it all off, in addition to the 81 shots that are already quasi-mandated, the trusting parents — many of them apparently believers in what Siri calls "the religion of vaccines" — are urged by pediatricians to add at least 6 other vaccines, some of them in multiple doses. Although a sea change of weakening public trust, even ouright rejection of all of the "recommended" shots in the "childhood schedule" of Figure 1 is evidently taking place (Zadrozny, 2024; also see Bigtree, 2025b; and the McCullough Foundation, 2025), the "childhood" schedule of vaccines is still treated as mandatory by many states, schools, and businesses. Similarly, the CDC continues to promote and recommend exceedingly harmful add-ons to the schedule such as the human papillomavirus vaccines (Lee, 2021; DeLong, 2021a, 2021b) for adults — and pediatricians are now advised in the fine print on page 4 to urge parents to give one or more of the COVID-19 "vaccines" in at least 2 doses to children as early as 6 months to 2 years of age. For an argument against giving children any of the COVID-19 shots, see Hughes (2021). The childhood schedule at the time of this writing includes the following wording addressed to pediatricians and their patients:

> Administer an age-appropriate COVID-19 vaccine product for each dose. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

If we follow this link (on 2025-11-06) which is supposed to explain how "shared clinical decision-making" works for the COVID-19 shots, we find that the CDC recommends 2 doses of Spikevax Moderna for "ages 6–23 months previously vaccinated with Pfizer-BioNTech COVID-19 Vaccine" that they "should receive [additional] dose(s) of 2025–2026 Moderna COVID-19 Vaccine". For children "2–4 years" old whether or not they were dosed previously for COVID-19 at least 1 more dose is recommended. For those at 5–11 years, another dose of Spikevax is urged, and for those from 12 to 64 years of age, it seems that at least 2 additional doses are "recommended" from any of the following choices: Moderna (mNexspike), Moderna (Spikevax), Novavax, or Pfizer-BioNTech COVID-19, and in any convenient combination. Besides engorging the vaccine schedule still further with the COVID-19 concoctions, additional shots are also recommended for "Meningococcal B (MenB) . . . for adolescents and young adults aged 16–23 years"; Hepatitis B (HepB) . . . for adults aged 60 years and older with diabetes mellitus"; "human papillomavirus (HPV) . . . for adults aged 27–45 years"; "pneumococcal conjugate vaccination (PCV20 or PCV21) for adults aged 65 years and older who have completed the recommended vaccine series with both PCV13 (at any age) and PPSV23 (which was administered at age ≥65 years)"; and "additional doses of COVID-19 vaccination for people who are moderately or severely immunocompromised".

CDC Experts Take a Stand on Depressed Immune Defenses

The CDC experts argue that people with depressed immune defenses, or with the cumulative injuries and other morbidities known to be universally associated with aging according to the Gompertz Law of Mortality (see the discussion of that law by Oller & Santiago, 2025), will be most likely to benefit from the injurious and even lethal COVID-19 shots (Trozzi, 2023). The research, however, shows that the older and more injured a person is, the more harmful the COVID-19 shots will be and the sooner the person will die. One dose of the poisons is bad, two are worse, and so on up to any number of shots that a person is willing, or may be forced in a hospital or assisted care facility, to receive until at about the number 5, according to Medicare statistics obtained by Steve Kirsch, days-left-to-live diminish, on the average, to about 58 (Santiago & Oller, 2023).

The "childhood vaccines" that are "recommended" as summarized in Figure 1, are also supplemented by a "catch-up" schedule with myriad details appearing in fine print over an additional 14 pages with tables, notes, and appendices. All 15 pages together are evidently intended to enable pediatricians advising the parents at "well visits" to coax, cajole, frighten, or in some manner press the children's parents into acquiescing to all the recommended shots (Chaufan et al., 2022; Diekema, 2022). The research shows that "fear" in one form or another plays the dominant role (Kyrie & Broudy, 2022b; Gilan et al., 2023; Broudy, 2025). Even in 2025, after the whole world has seen the disastrous consequences of the COVID-19 concoctions (Beattie, 2021; Oller & Santiago, 2022; Santiago, 2022; Kirsch, 2023; Santiago & Oller, 2023; Mead, Seneff, Wolfinger, et al., 2024; Mead, Seneff, Rose, et al., 2024; Hulscher et al., 2024; Szebeni & Koller, 2025; Speicher et al., 2025), the CDC is still urging parents to consider adding doses of some variant(s) of the COVID-19 shots to the recommended childhood schedule. Later in adolescence and adulthood, multiple doses of humanpapillomavirus (HPV; now for people in their 20s and up), Dengue fever (DEN4CYD:9-16 yrs), and monkeypox (Mpox) are recommended.

Relevant independent research, not paid for or sponsored by the pharmaceutical interests, shows increasingly that the vaccines being promoted by the technocrats in the shadowy background (Johnson et al., 2024), the pharmaceutical manufacturers in the foreground, and the captured federal agencies in plain sight are doing incalculable harm (Kyrie & Broudy, 2022a; Oller & Santiago, 2025; Hulscher et al., 2025; de Diego-Cabanes et al., 2025). Independent researchers in the medical profession have begun to focus attention not on the advertising and marketing slogans for selling vaccines to the general public — e.g., the "safe-and-effective", "vaccines-save-millions-of-lives" promoted by the pharma-owned and controlled mainstream medical journals, medical schools, hospitals, etc. — but rather on the outcomes in a growing multitude of carefully designed research studies, some of which are cited in the previous paragraph. As a result of such research the Surgeon General of Florida, Joseph Ladapo, MD, PhD, on November 18, 2022 took action to ban COVID-19 vaccine mandates on November 18, 2022 (Diamond, 2022) and on September 3, 2025 announced the move to ban all mandates of all the vaccines used in that state (Wood, 2025). By February 14, 2025, Louisiana's Surgeon General, Ralph Abraham, MD, not only followed suit in opposing all mandatory vaccination but was promptly promoted to a federal position as Principal Deputy Director at the CDC (Associated Press, 2025).

Even more recently, another indication of the changing tide of public opinion and political responsiveness to independent research on adverse vaccine outcomes, is the recent change on the CDC website backing off (as of November 19, 2025) from the strong claim that "vaccines do not cause autism". They now say:

> The claim [that] "vaccines do not cause autism" is not an evidence-based claim because studies have not ruled out the possibility that infant vaccines cause autism.

The stronger version of that claim was often made by Paul Offit, MD, who netted millions of dollars from his own Rotavirus vaccine, RotaTeq, marketed by Merck and included within the CDC schedule for children from birth to age 18 (see Figure 1 above and Attkisson, 2008). It was Offit, along with others, who argued explicitly that babies ought to be able to handle as many as "10,000 vaccines at any one time" (Offit, et al., 2002, p. 126) — this, presumably at birth, or on a single "well-baby visit" to the pediatrician. Offit and his colleagues, however, were relying on a brand of evolutionary theory advocated by Cohn and Langman (1990) that has since been substantially revised. They also relied on a theory about the number of antibodies that could be produced, not by the immature immune defenses of a baby, but that could be produced by the mature defenses of an adult.

Their argument, which is quoted just below this paragraph in some detail in the indented style of this journal with American punctuation and active hyperlinks, was phrased in terms of the vast number of antibodies — known to be greater than ten billion for a mature adult — at least since the publication of Tonegawa, et al. (1974). That work led to a Nobel Prize for Susumu Tonegawa (1976, 1988; as discussed in Oller, 2022a, pp. 31, 244-260). Offit and colleagues also relied for their claim about babies being able to tolerate "10,000 vaccines at any one time" — presumably in a single injection — on Cohn and Langman (1990) whose work they cited three times in the part of a single paragraph quoted below. The latter authors, Cohn and Langman, accepted the central dogma of Crick about the unidirectional flow of information from DNA through RNAs to proteins. That dogma would soon be disproved (see Pellionisz, 2006, 2008, 2012). Their argument was also consistent with Ohno's theory (1999), also disproved many times over (see Oller, 2010; Pellionisz, 2012; Oller, 2022a, pp. 73-74), that most of our DNA (about 98% of it) consists of useless junk left

over from millions of years of evolution. Presumably, without taking those huge theoretical changes into account, Offit and his colleagues offered the following defense for their inference that "each infant [any baby whatsoever] would have the theoretical capacity to respond to about 10,000 vaccines at any one time". Here is the context:

> If we assume that 1) approximately 10 ng/mL of antibody is likely to be an effective concentration of antibody per epitope (an immunologically distinct region [that is, a region that can be targeted by a given antibody] of a protein or polysaccharide) (Cohn & Langman, 1990), 2) generation of 10 ng/mL requires approximately 10^3 B-cells per mL 3) a single B-cell clone takes about 1 week to reach the 10^3 progeny B-cells required to secrete 10 ng/mL of antibody (Cohn & Langman, 1990) (therefore, vaccine-epitopespecific immune responses found about 1 week after immunization can be generated initially from a single B-cell clone per mL), 4) each vaccine contains approximately 100 antigens and 10 epitopes per antigen (i.e., 10^3 epitopes), and 5) approximately 10^7 B cells are present per mL of circulating blood (Cohn & Langman, 1990), then each infant would have the theoretical capacity to respond to about 10,000 vaccines at any one time (obtained by dividing 10^7 B cells per mL by 10^3 epitopes per vaccine) [Offit et al., 2002, p. 126).

What was wrong about such blanket claims in favor of administering an increasing number of childhood vaccines was the notion that any number of empirical studies could ever prove the null hypothesis that "vaccines do not cause autism".

A Foolish Goal: To Prove a Null Hypothesis by Experimental Study

It is possible, of course, to refute an empirically testable null hypothesis with a single experimental exception. For instance, the null hypothesis that there was no gold in California was disproved on January 24, 1848 when James W. Marshall discovered gold at Sutter's Mill. The null hypothesis that no man would ever run a mile in under 4 minutes was disproved on May 6, 1954 by Roger Bannister at Oxford's Iffley Road Track. The null hypothesis that autism cannot be caused by vaccines was disproved in a dramatic empirical court case decided on September 15, 2010 when a federal Vaccine Court (formerly the People's Court) awarded more than $20 million dollars to Hannah Poling's family acknowledging that her diagnosis of severe autism was caused by vaccines.

Because it only requires a single empirical case to refute a null hypothesis that purports to apply to all possible material instances that might possibly ever be found, it is unacceptable to suppose that any number of empirical studies failing to refute a null hypothesis could prove it to be true. The null hypothesis that vaccines do not cause autism could never be proved by any number of experimental procedures that might fail to find an empirical association. By contrast, a single instance showing a clear causal relation is sufficient to disprove such a general null hypothesis.

However, a null hypothesis by null results is a fool's goal. There can never be enough null outcomes to proved that the null hypothesis, supposedly under examination — e.g., that "vaccines do not cause autism" — is true for all possible experimental settings. To complete such a task with experimental research is not just difficult, it is completely impossible. No matter how many searches for gold in California might fail, all of them together could never prove the null hypothesis that there is no gold in California. No matter how many efforts to run a mile in under 4 minutes may fail, they can never prove the null hypothesis that such a feat is impossible. Similarly, no matter how many studies the CDC might pile up claiming to have found no causal relation between vaccines and the diagnosis of autism, the whole pile can be refuted by a single exception. What makes that particular claim about vaccines and autism an obvious falsehood is that there are many empirical studies that disprove it including the one summed up above in Figure 2.

In a technical paper addressing the general impossibility of proving a null hypothesis by any number of failed attempts to disprove it empirically is loosely described by Wagenmakers (2007, p. 779):

> . . . the null hypothesis is never exactly true, and will therefore always be rejected as the number of observations grows large.

Of course, it is necessary to take account of the fact that Wagenmakers was speaking of null hypotheses of an empirical kind that are not susceptible of mathematical proofs. With respect to the general theory of signs, it is possible prove a series of powerful null hypotheses — e.g., that only true narrative representations (TNRs), but no fictions, no errors, no lies, and no combinations of the latter can ever be found (no matter how large the datasets may become) that have the unique properties of determinacy, connectedness, and generalizability (see Peirce, 1897; Tarski, 1941; Oller, 2010, 2014).

Bearing that in mind, we can say with algebraic certainty that there can never be enough empirical studies on hand to prove the false null hypothesis that "vaccines do not cause autism". That notion has been falsified many times over in empirical studies, so it is already known to be false, and therefore cannot be proved true because it is already known to be false. However, for the CDC to have ever put forward such a null hypothesis, as if it could ever be proved empirically, is indefensible because it is a logical absurdity. Neither the strong version of that null hypothesis that was often promoted by Paul Offit and colleagues, nor the weaker one that remains on the present-day CDC website at the time of this writing, should ever have been entertained by people who have a modicum of understanding of statistical and mathematical reasoning. On the latter account, the claim is not only obviously false on the basis of an abundance of ready-to-hand empirical evidence (the Poling case, the Garner studies, the McCullough Foundation studies, and many papers published in this journal and elsewhere by independent researchers), but is a falsehood grounded in a mistaken view of statistical reasoning.

A Voluntary, Unsolicited Peer-Review

Before digging a little deeper into the Lamerato et al. results (see our Table 1 which replicates and amplifies their Table 2), we hope we have already made it clear from relevant independent research studies that the claims about vaccines being "safe and effective" are marketing strategies pretentiously presented as "research" or, in the words of Anthony Fauci (see R.F. Kennedy, Jr, 2021) "settled science" — of which there is none (Marks II, 2025). As Siri (2025) makes clear in reference to the Henry Ford Health System project comparing vaccinated against unvaccinated birth cohorts — the same study that was discussed at the US Senate Hearing conducted by Senator Ron Johnson of Wisconsin on September 9, 2025 — blanket claims about the "safety and effectiveness" of vaccines are based in a false religion, a belief system that has no basis in reality. With that in mind, examining more closely the outcomes reported by Lamerato, et al. (2020-2025) in their unpublished report is certain to be useful and informative. As noted in the documentary by Bigtree (2025a), the results obtained were so repugnant to the employing institutions and so damaging to the mainstream narrative about "safe-and-effective" vaccines, that they were severely constrained in what they could say in their report and retain their jobs and reputations. As we dig a little deeper into their results with reference to our Table 1, our review will show that the study is more devastating to the false beliefs about vaccines than the employers of Lamerato et al. would allow them to say, and, along with the recent study by Hulscher et al. (2025), is another death knell to the false assertion that "vaccines do not cause autism".

Table 1

In Columns 2 – 6 and in Rows 1 – 22, What Appears Here Is Table 2 from Lamerato et al. (2020-2025): It Is Reproduced for Detailed Re-Examination in Which: the 5 Rightmost Columns Give Proportional Values from Columns 3 and 4, Rank Orders of Respective Numbers in the Rightmost Pumpkin Colored Columns, and the Usual Descriptive Statistics Totals, Means, Variances, and Standard Deviations Are Added in the 4 Rows at the Bottom

Column	1	2	3	4	5	6	7	8	9	10
Row #	**Outcome**	**Vx**	**NoVx**	**$Vx_{pt\text{-}y}$**	**$NoVx_{pt\text{-}y}$**	**Vx/16511**	**NoVx/1957**	**Col 6 – Col 7**	**$Rank_{Vx}$**	**$Rank_{NoVx}$**
1	Chronic Health Condition	4732	160	277.3	111.7	0.2866	0.0818	0.2048	33	32
2	Asthma	2867	52	145.6	35.6	0.1736	0.0266	0.1471	31	30
3	Atopic Disease	946	23	41.2	15.6	0.0573	0.0118	0.0455	29	24
4	Autoimmune Disease	201	2	8.4	1.4	0.0122	0.0010	0.0112	19	6
5	Brain Dysfunction	8	0	0.3	0	0.0005	0.0000	0.0005	2	1
6	Cancer	169	13	7	8.8	0.0102	0.0066	0.0036	16	20
7	Diabetes	42	0	1.7	0	0.0025	0.0000	0.0025	7	1
8	Food Allergy	577	30	24.3	20.5	0.0349	0.0153	0.0196	28	26
9	Mental Health Disorder	341	5	15.9	4.5	0.0207	0.0026	0.0181	25	12
10	Neurodevelopmental Disorder	1029	9	50.2	8.2	0.0623	0.0046	0.0577	30	17
11	ADHD	262	0	12.1	0	0.0159	0.0000	0.0159	22	1
12	Autism	23	1	1.1	0.9	0.0014	0.0005	0.0009	5	4
13	Behavioral Disability	165	0	7.6	0	0.0100	0.0000	0.0100		1
14	Developmental Delay	219	5	10.1	2.7	0.0133	0.0026	0.0107	21	10
15	Learning Disability	65	0	3	0	0.0039	0.0000	0.0039	11	1
16	Intellectual Disability	5	0	2.1	0	0.0003	0.0000	0.0003	9	1
17	Speech Disorder	463	6	21.8	5.4	0.0280	0.0031	0.0250	27	14
18	Motor Disability	150	2	6.9	1.8	0.0091	0.0010	0.0081	15	8
19	Tics	46	0	2.1	0	0.0028	0.0000	0.0028	9	1
20	Other Psychological Disability	9	0	0.4	0	0.0005	0.0000	0.0005	3	1
21	Neurological Disorder	127	12	5.2	8.1	0.0077	0.0061	0.0016	13	17
22	Seizure Disorder	319	12	13.3	8.2	0.0193	0.0061	0.0132	23	18
23	Total of Chronic Health Conditions	12765	332	657.6	233.4	0.7731	0.1696	0.6035	378	246
24	Mean	580.227	15.091	29.891	10.609	0.035	0.008	0.027	18	11.182
25	Variance	1246868.28	1207.42	4032.09	584.38	0.00	0.00	0.00	98	109.108
26	Standard Deviation	1116.633	34.748	63.499	24.174	0.068	0.018	0.051	9.899	10.445

Blanket Denials of the Lamerato et al. Findings

Although the study in focus was maligned in the popular press by Jennifer Sandlin (2025) reporting for MSN News and it was also critiqued by a collection of vaccine promoters associated with the site known as "Science Feedback", the observed outcomes of the study, as we show, are irrefutable. First, we deal with Sandlin, and then with the "Science Feedback" commentary, and then we go on to a few detailed comments on the Lamerato et al. study as they wrote it up in 2022. Whereas the CDC praises itself in its own government sponsored and controlled publication (F. E. Shaw et al., 2011), the *MMWR* [*Morbidity Mortality Weekly Report*] (1999) for its vaccination schedule as its greatest achievement, Lamerato et al. admit early in their paper that the CDC has produced a "paucity of data" to show that the CDC "recommended" vaccines are either "safe" or "effective".

Journalist Sandlin and Jake Scott, MD

In her critique of Lamerato et al., Sandlin almost exclusively quoted the one MD, Jake Scott — a Stanford professor of infectious diseases — who appeared at the Senate hearing to defend the CDCs' vaccine schedule. In commenting on Lamerato et al., Scott claimed the comparison of vaccinated to unvaccinated children in the Henry Ford Health System was unfair. He challenged the observed findings based upon presumptions already embedded in the time-tested marketing strategies peculiar to the pharmaceutical industry. He questioned, for instance, the validity, of the Lamerato et al. finding (see row 11 of Table 1) that there were 262 cases of diagnosed ADHD in the vaccinated group but none in the unvaccinated. He based this objection on the national prevalence of the ADHD diagnosis, which he said, stands at 11%. Therefore, he implied, we should expect to see at least some cases, perhaps as many as 215? among the 1,957 unvaccinated cohort in the Henry Ford Health System. With the same sort of reasoning — based on nothing but faith in the pharmaceutical religion of faith in vaccines — he doubted the "six to eightfold" contrast "in ear infections among vaccinated children" (not seen in Table 1) saying "there is no plausible scientific explanation as to why vaccines would increase ear infections".

But, his defense of the mainstream vaccine narrative requires ignorance of the known harmful effects of the toxicants in vaccines that dramatically suppress human immune defenses. Scott also said that the authors found "no association between vaccines and autism", but that claim concerning association is false. In fact, if we compare proportional outcomes in columns 7 and 8 of Table 1, from row 8 downward disregarding cancer, diabetes, and "Other Psychological", including only symptomatic descriptions often applied to children diagnosed with autism, the odds ratio favors the unvaccinated children by a factor of 5.49. For the diagnostic symptoms commonly seen in children on the "the autism spectrum" (see chapter 5 in Oller et al., 2010, 2025) — brain dysfunction, food allergy, mental health disorder, neurodevelopmental disorder, ADHD, autism, behavioral disability, developmental delay, learning disability, intellectual disability, speech disorder, motor disability, tics, neurological disorder, and seizure disorder — the average proportion of vaccinated children in these categories was 0.230 contrasted with 0.0419 for the unvaccinated cohort.[2] This contrast produces an

[2] It is not entirely clear how subjects were identified for the study, but we have this in the words of Lamerato et al. page 4 of their write-up: "This retrospective study evaluated health outcomes of a consecutive cohort of children born between 2000 and 2016 and enrolled in HAP [the Health Alliance Plan]. This cohort was identified using the HAP and HFHS [the Henry Ford Health System] administrative database. Subjects were observed from birth until the earlier of disenrollment in the plan or December 31, 2017." In their explanation of how some participants were excluded, it appears to us that they biased things as much as possible in favor of the vaccinated group. They say that their "exclusion

odds ratio favoring the unvaccinated children by 549.13%. That is to say, ending up in the injured and diseased side of the ledger is that much more likely for the vaccinated cohort.

Table 2
"Birth Characteristics and Demographics Stratified by Vaccine Exposure † Status"
as Presented in Table 1 of the Lamerato et al. Report with Colored Parts Added

Row #	Demographics	Study Population (n=18,468)	No Vaccine (n=1,957)	Any Vaccine (n=16,511)	*p*-value
1	**Male**	9,395 (51%)	1,077	8,318 (50%)	<0.001*
2	**Race**				<0.001**
3	**White**	6,858 (37%)	900 (46%)	5,958 (36%)	
4	**African American**	6,625 (36%)	453 (23%)	6,172 (37%)	
5	**Asian**	1,131 (6%)	87 (4%)	1,044 (6%)	
6	**Hispanic**	503 (3%)	31 (2%)	472 (3%)	
7	**Other**	3,351 (18%)	486 (25%)	2,865 (17%)	
8	**Birth weight ‡**				<0.001
9	**Normal**	17,701 (96%)	1,907	15,794	
10	**Low**	539 (3%)	21 (1%)	518 (3%)	
11	**Very low**	228 (1%)	29 (2%)	199 (1.2%)	
12	**Prematurity**	1,063 (6%)	34 (2%)	1,029 (6%)	<0.001
13	**Respiratory Distress at Birth**	685 (4%)	26 (1%)	659 (4%)	<0.001
14	**Birth Trauma**	200 (1%)	4 (0%)	196 (1%)	<0.001
	Vaccine Injections				
15	**0**	1,958 (10.6%)	1,958		
16	**1-10**	3,330 (18.0%)		3,330	
17	**11-20**	7,476 (40.5%)		7,476	
18	**21-30**	4,981 (27.0%)		4,981	
19	**>30**	724 (3.9%)		724 (3.9%)	

† Vaccine exposure for the purpose of comparison of baseline characteristics was receipt of any vaccine during enrollment in the plan.

‡ Birth weight (Normal > 2,500g; low birth weight = less than 2,500g; very low birth weight = less than 1,500g).

*It appears that the parents refusing to conform to the CDC schedule did so more frequently on behalf of their male children than for their female children. This contrast is consistent with the fact that boys are known to be more severely injured by toxicants, in general, than girls.

**Minority parents were, it seems, more likely to be coerced to go along with the CDC schedule.

In fact, contrary to the marketing mantra that the "vaccines are safe and effective" there is compelling indirect evidence that the parents, especially the mothers, of the vaccinated cohort were less healthy before the birth of the children in the Henry Ford Health Center who were destined to be part of the vaccinated cohort in the Lamerato et al. study. In our judgment, the most plausible reason for the fact that the children to be vaccinated by their parents were less healthy at birth than

criteria" included "chromosomal abnormalities, cerebral palsy, cystic fibrosis, spina bifida, congenital heart disease, or brain, neurological, or other congenital conditions present or discovered after birth. These exclusions correspond with the objective of evaluating long-term health outcomes in a generally healthy birth cohort" (pp. 4-5). However, their own demographic data in their Table 1 (our Table 2 in this document) showed the vaccinated group was a great deal less healthy to begin with, so it is a near certainty that the "exclusions" noted were of children predominantly from the vaccinated group which was notably less healthy to begin with.

those who were destined to be part of the unvaccinated cohort would be the vaccination status of the parents themselves. Those parents opposed to the vaccination of their children would almost certainly be consistent by also rejecting vaccinations for themselves as well. This fact is the probably correct interpretation of the differences between the vaccinated and unvaccinated cohorts (all significant at $p < 0.001$) at birth. The children in the unvaccinated cohort were significantly less likely to be born prematurely, to have abnormally low birth weight, to experience "respiratory distress at birth", and to experience "birth trauma" (see our Table 2).

Based on relevant research contrasting parents who favor vaccination for their children versus those who do not (Gilan et al., 2023), those who are likely to conform to the CDC schedule for their children are likely to conform to a similar degree to the schedule recommended for themselves. Again, based on the relevant research by Garner (2022), the children of any mother who took shots before becoming pregnant — the ones recommended are shots for whooping cough, flu, respiratory syncytial virus, and measles-mumps-rubella — or during the gestation of that child during which the recommended shots are flu vaccines, along with the whooping cough, and respiratory syncytial virus, if not taken prior to the pregnancy, as well as shots for Hepatitis A and B, if the doctor suspects either of these to be a threat. Vaccinations of one or both parents at any time before, but especially in temporal proximity to, or during the mother's pregnancy — with shots received by the mother during her pregnancy being the most likely to cause problems detectable at the child's birth (see our Table 2) — are the most likely cause of the poorer health of the vaccinated cohort even before the study was even getting underway.

Jake Scott, in our estimation, is entirely correct in supposing that the vaccinated children — whose parents were certainly more likely to be vaccinated than the parents of the unvaccinated cohort — begin life at a disadvantage relative to the children of less vaccine-exposed parents. The children of the less vaccinated parents — who are destined themselves to remain unvaccinated because of their parents' wishes — will also remain healthier throughout their childhood and adolescence because they are, and will remain, less exposed to the injectable toxicants in the CDC vaccine schedule.

The Science Feedback Group Defends the CDC Vaccine Schedule

Next, we address the dismissive critique of Lamerato et al. (2022) recently published on the website known as Science Feedback (2025). The latter is an entity purportedly combatting "disinformation" — particularly, according to their list of editors at https://science.feedback.org/about/ on the screen showing "Who We Are" — they aim to refute publications about Climate Feedback and Health Feedback which dispute the theory of "global warming" or the claims that vaccines are almost universally "safe and effective". They believe in the former and universally support the latter. With respect to the "science" about vaccines, the reviewers and editors at Science Feedback identify as "disinformation" anything that challenges the corporate "safe and effective" mantra or that suggests the captured government agencies are doing the bidding of the vaccine manufacturers. The authors at Science Feedback, or more likely the AI bots supposedly directed by them, generated the claim about the Lamerato et al. (2020-2025) methodology that it — and, by implication, all comparisons of vaccinated against unvaccinated patients that are like theirs — "stack[s] the deck against the vaccinated group, creating the illusion that they're more prone to illness".

The Science Feedback group commented that "the higher rates of chronic medical conditions [e.g., lower birth-weight, prematurity, respiratory distress at birth, and birth trauma] seen in vaccinated children (our Table 2 on lines 8, 12, 13. and 14; from their Table 1) could be due, in part, to the greater frequency of birth-related risk". Setting aside the circular reasoning, which begins and ends

with increased birth-related risks that must in some way cause themselves to increase, the obvious intent is to say that the children who were destined to receive one or many doses of vaccines from the CDC schedule were sicker to start with. The implication is that the "unvaccinated" children had an unfair healthy head start, or that the to-be "vaccinated" children had already fallen behind and were less healthy before the race began. Both readings are probably true, but both options are also probably already due to the harmful impact of vaccines prior to the beginning of the study. Here is why, in all probability, the children destined to receive from 1 to more than 30 vaccines (Table 2, row 19) are less healthy than those who are destined to receive none at all (Table 2, row 15).

It is noteworthy that in the Cox proportional hazards model, the list of "Outcomes" at the left (Table 1 above) are all bad things to be avoided if possible. Isn't it highly probable that the children destined to receive one or more doses of "safe and effective" vaccines would also be the offspring of parents who are also, proportionately, more likely to be vaccinated, especially the mothers? Would vaccinating the mother before the child's birth produce the apparent headstart for the unvaccinated children that is seen in our Table 2? Data from Garner (2022) showed, as expected from biosemiotic theory (Oller, 2010; Gryder et al., 2013; Oller, 2014; Shaw et al., 2014; Kennedy et al., 2016; Shaw, 2017; Oller, 2022), that children whose mothers refused all the CDC recommended maternal vaccines, and also refused the Vitamin K shot commonly administered at birth, had by far the lowest incidence of chronic disease. By contrast, the children of mothers who took the recommended vaccines during their pregnancy and allowed their child also to be injected with a Vitamin K shot at birth were far more apt to be later diagnosed with at least 1 chronic disease condition. As the record shows in our Table 1, and what follows it, the undesirable diagnosis of any disease condition is what forces the vaccinated children to circle back and forth from the doctors injecting them with challenging disease agents and toxicants and the same doctors treating them for chronic diseases guaranteeing that the vaccinated cohort will be much sicker than the unvaccinated. The children receiving the shots are getting ever so many more "opportunities" than the unvaccinated children for doctor visits, visits to an emergency room, a stay in the hospital, and so forth just as the relevant independent research shows to be the case (Goldman & Miller, 2012; Hooker & Miller, 2021).

Intelligent Patients See Bad Outcomes and Then Say "No" to Next Dose

As Oller and Santiago (2025) noted in their study of the US Medicare patients who died between the middle of the COVID-19 pandemic and the last day of 2022, the fact that fewer and fewer of potential recipients were willing to take the next dose in the series of the COVID-19 vaccines that were supposed to be saving lives, had to be understood as an "intelligence" measure. Also, as research cited by Siri (2025; pp. 2-3) shows, the people refusing the vaccines have higher educational background than those who follow what Siri calls "the vaccine religion" and take all the shots for themselves and their children. The more informed the individuals are, the more likely they will notice that the shots are doing harm rather than good, and the more likely they will reject the next dose in the CDC recommended series.

Much was made of the difference in "median enrollment time" for the vaccinated and unvaccinated groups by the vaccine promoters at Science Feedback. The biostatistician and professor at the University of Pennsylvania, Jeffrey Morris, said that because vaccinated children had 7 annual clinic visits, versus 2 for the unvaccinated group, that "ascertainment bias" — the difficulty, hypothesized to exist by Morris, of discovering actual chronic disease conditions in the unvaccinated group — was the whole explanation for the contrast between vaccinated and unvaccinated cohorts. He singled out "attention deficit hyperactivity disorder (ADHD)" which he said, "commonly requires three to four clinic visits to diagnose". What he failed to mention, however, is that getting 18 doses of the

vaccines in the CDC Schedule required about 18 visits (or more) for at least half of the 16,511 patients who received them.

How many visits would be required for the patients who received no vaccinations at all? Zero visits. All 1,957 of them made no visits whatsoever to take advantage of the "opportunities" provided them by the Henry Ford Health Center. Ignoring that flaw in his argument, Morris continued to claim that "the lower incidence of chronic health conditions seen in the unvaccinated group could be explained by this group being less likely to see the doctor . . . rather than because this group was healthier". But, of course, healthier patients are less likely to see themselves as needing to see the doctor, so Morris's argument is self-defeating. In fact, the flawed logic shows the deceptive intention contained in the phrase " well-visits" that the CDC uses almost exclusively to usher babies and older children in to "see the doctor", so they can be vaccinated.

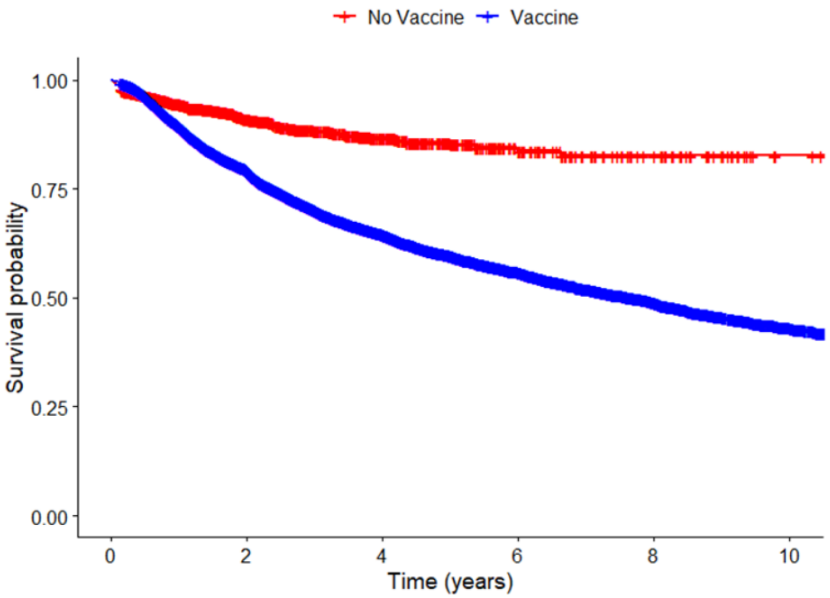
At the same time, since pediatricians are more apt to see through the pretense of "well visits", they must be incentivized, it may be hypothesized, to look the other way when problems arise and they must be trained to explain away the fevers, the supposedly "benign seizures", the occasional anaphylactic deaths, that sometimes occur soon after administering a dose of vaccine. Typically they attribute the crib deaths to the mysteries of a plethora of alphabet descriptors all manifesting in the same way. There is, for instance, SIDS [sudden infant death syndrome], SUDI [sudden unexpected death in infancy], or SUID [sudden unexpected infant death] always attributed by the mainstream professionals to anything but vaccines, e.g., to "bedsharing" (Chiu, Elder, & Zuccollo, 2012), sleeping position, exposure to cigarette smoke and drugs, failure to keep up the vaccination schedule, breastfeeding, room-sharing even without bed-sharing, avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs (American Academy of Pediatrics, 2011). However, the one thing that the mainstream spokespersons seem always rule out as a possible cause of crib death is vaccines. John Iskander, MD, and US Navy Captain at the Defense Health Agency, speaking for the CDC said in 2009 at a press conference that is no longer available on-line: "The bottom line is still that we do not know what causes SIDS and the other bottom line from a number of studies is that vaccines are not the culprit" (quoted by Oller, Oller, & Wakefield, 2010, p. 18). The only possible basis for Iskander's claim is the false null hypothesis that vaccines do not cause any kind of harm, so they cannot possibly be faulted in the vast number of crib deaths occurring.

All the while, the pediatrician is reassuring parents that the injectables are the best defense for their children, for themselves, and the population at large. The parents are encouraged to believe the specious claim that by subjecting their children to the toxic challenges of as many as 81 doses or more by the age of 18, not to mention the shots the parents themselves are encouraged to receive as adults, that they are ensuring the health and well-being for the future of all concerned, including the greater society at large. But the outcomes found by Lamerato et al. show that none of that is true.

Therefore, the less healthy condition of the children later to be vaccinated (as seen in Table 2) is almost certainly because the mothers giving birth to these 16,511 soon-to-be-vaccinated children are themselves to some extent already vaccine-injured in ways that negatively impact their offspring. Certainly, they are more likely than the mothers who are going to refuse all vaccines for the 1,957 children in the unvaccinated group at Henry Ford Health System to have accepted one or more vaccines before or during their pregnancy. They are, we must suppose, more likely to follow the recommendations of the CDC concerning vaccinations both before and during their pregnancy. They are more likely, also, to go along with the Vitamin K shot for their baby at birth.

Then there is the matter of "the follow-up" time, however it may be defined. The Science Feedback critics, including Jeffrey Morris presumably, seem not to take account of the fact that more illnesses in the vaccinated group would be the most likely explanation for the need for a "longer follow-up" time frame by any definition of the latter. Children diagnosed at any time with chronic disease(s) are more apt to be perceived by clinicians as needing follow-up — a return visit to see the doctor after some lapse of time — and diseased children are more apt to get some follow-up visit, or a plurality of visits, than children who are not diagnosed and don't need any such disease-related follow-ups. However, given the salient and significant differences in the vaccinated and the unvaccinated groups both at the start and at the end of the Lamerato et al. (2020-2025) study, is it unreasonable to infer that the sicker children — the vaccinated ones — would be in the clinic more frequently and would require more monitoring by their parents and doctors?

After noting that "the median follow-up time for vaccinated children was 2.7 years" while the median time for unvaccinated was "1.3 years" — Morris dismisses the three additional follow-up studies conducted by Lamerato et al. (2020-2025). Given the misleading complaint that the unvaccinated children had fewer doctor visits and a shorter time in which to be diagnosed with any of the neurodevelopmental disorders that are typically not identified until about the age of 3 years, Lamerato and colleagues compared results at "one year or more, three years or more, and five years or more", and we should add, they also conducted a follow-up as far out as 10 years which was represented in their colorful figure which we include here as our Figure 3. As depicted in Figure 3, the Kaplan–Meier survival analysis revealed that only 43% of vaccinated children remained free of chronic illness at 10 years, compared with 83% of unvaccinated children — meaning 57% versus 17% had developed at least one chronic condition. This three-fold disparity persisted across all sensitivity analyses, underscoring the robustness of the finding and the sustained divergence in long-term health outcomes between cohorts. Morris complained further that each of those follow-up studies "actually amplifies the imbalance". Why? Because he argues, "there were about 20 times more vaccinated children than unvaccinated children in the five-year follow-up group". We agree with the obvious fact that there were more patients in the vaccinated cohort by a factor of 8.437 (= 16,511/1,957) but the contrast in sample sizes could be vastly greater, and it would still have no



Vaccine	1.00	0.79	0.65	0.56	0.49	0.43
No Vaccine	1.00	0.91	0.87	0.84	0.83	0.83

Figure 3. Lamerato et al. designated this figure as a "Kaplan Meier Curve" showing the "10-year chronic disease-free survival by vaccine exposure" contrasting the vaccinated cohort on the blue line with the unvaccinated on the red.

real impact on the fact that the vaccinated group is a great deal sicker than the unvaccinated. The sample-size after it surpasses the number 25 in each cohort becomes irrelevant on account of the central limit theorem. It shows that the representativeness of an infinite number of random samples of a given *n*-size drawn from the same, or very similar populations, improves very little from after *n* reaches the number 25. From a random sample of only 25 persons, reliable and valid inferences about the population as a whole can reasonably be drawn, and the representativeness of the sample relative to the whole population improves very little as the sample size approximates the number of cases in the whole population (Pólya, 1920; Le Cam, 1986; Zabell, 1995). With the sample sizes used by Lamerato et al., Morris's worry about the number of observations is little more than a fiction.

The sample sizes relied on by Lamerato et al. (2020-2025) greatly exceed the minimum of about 25 needed to sustain their analyses. The probability that the vaccinated patients in the sample of 16,511 are much less healthy than the vaccinated population throughout the USA is exceedingly small. It can, in fact, be ruled out as a vanishingly unlikely improbability. The 16,511 individuals in the vaccinated cohort at the Henrey Ford Health Center are almost certainly very much like, the rest of the vaccinated individuals who were similarly exposed to the CDC schedule throughout the nation in the period from 2000 to 2016 (see footnote 2 above).[3]

FAILED ARGUMENTS AGAINST LAMERATO ET AL.

The self-destroying aspect of Scott's defense of the CDC vaccine schedule — and that of the Science Feedback group as well — is not their presumptuous reliance on marketing slogans promoted by doctors, nurses, and clinicians in clinics, hospitals, medical schools, universities, and health management organizations, pharmaceutical advertisements, and the vast number of people in the general population compliant with the CDC schedule, all of which is supported by billions, even trillions of dollars committed by the pharmaceutical industry to vaccines (E. P. I. C. Magazine, 2017) — the self-demolishing element of their argument is the claim that the greater number of doctor visits by the vaccinated cohort is the sole explanation for the large contrasts favoring the unvaccinated children in the Lamerato et al. data.

The problem faced by the critics of the Lamerato et al. study — and by any of those who may seek to deny the validity of the marked contrasts between the vaccinated and unvaccinated cohorts in that study — is that the scheduled vaccinations and their bad effects *are the only reasonable explanation for the greater number of doctor visits occurring in the vaccinated cohort*. The vaccines directly cause that contrast because the vaccinated children must regularly show up at some doctor's office or clinic first to get one, or several, doses of a vaccine — of which the minimal total stands at 297,198 which is the product of the median number of 18 vaccines per individual in the vaccinated cohort times the 16,511 individuals in that cohort who got all those shots— and, then when whatever chronic disease conditions the vaccines may causecome to light, additional visits are called for. All of this is plain in

[3] Regardless how much personal sympathy we may have for the individual doctors, nurses, clinicians, pharmacists, hospital administrators, medical professors, etc., that seem to want to do what is right, theoretical beliefs cannot outrank intelligible and replicable fact-based research findings. The theory that vaccines in general have unquestionable safety and efficacy must be adjusted to fit the facts. Not the reverse. Richard Feynman's rule still applies: if your theory is not consistent with empirical (experimental) outcomes, then it's wrong. As for the middle term in the name of this journal concerning "theory, practice, and research" — "practice", we believe, needs to be guided by valid theory and not by popular beliefs, opinions, voting, advertising, how many people said what, or believe something to be true, and so forth. Ultimately, empirical research is not like politics where majority voting reigns supreme. As researchers, we believe it is necessary to abide by the priority of actual outcomes.

the latter part of Table 2 above. It is the multitude of vaccination events — administered according to the CDC schedule (Figure 2) — that accounts for the average of 7 doctor visits for children in the vaccinated cohort in contrast to 2 visits for the unvaccinated. Therefore, the claim that the Lamerato et al. (2020-2025) study only measured "exposure to medical observation, not the effects of vaccines" defeats itself because that contrast is entirely owed to the CDC vaccine schedule.

The attempted rescue of vaccines by Scott and the Science Feedback group from the damning findings of Lamerato et al. condemns the vaccines with even greater certainty. The vaccines *are not only the cause of the contrast in disease conditions seen in Table 1, but they are also the primary if not the only basis for the greater number of doctor visits that are taking place in the vaccinated cohort.* Compliant parents, with unhesitating trust in the CDC, go to their pediatrician to get the shots and, then, after the shots trigger sickness in their children, they take them again and again to be treated for the disease conditions caused by the CDC scheduled shots.

As Marcia Angell, MD, who was then Editor-in-Chief of the prestigious *New England Journal of Medicine* put it, way back in the year 2000:

> If we had set out to design the worst system that we could imagine, we couldn't have imagined one as bad as we have. . . . we spend over twice what the next most expensive country spends on health care . . . And what do we get for it? . . . Our life expectancy is shorter [Starfield, 2000; National Research Council (US) & Institute of Medicine (US), 2013; Shmerling, 2022]. Our infant mortality is higher [Goldman & Miller, 2011; Miller & Goldman, 2012; D. Kennedy et al., 2016; Miller & Goldman, 2023; Mead et al., 2024].

Examining Lamerato et al. in Greater Detail

It is now clearer than ever before that the claims about vaccines being "safe and effective" are marketing tropes pretentiously presented as "research" or, in the words of Anthony Fauci (see R.F. Kennedy, Jr, 2021) as pronouncements of "settled science" — of which there is no such thing (Marks II, 2025).

In what remains of this paper, we want to distinguish between the reliable outcomes of the Lamerato et al. study and the flavoring of their findings with a sprinkling of marketing propaganda in order, as Zervos explained to Del Bigtree, for him to continue teaching at the Wayne State University School of Medicine, and for all 4 of the co-authors to keep their jobs and remain in the good graces of the Henry Ford Health Center.

Lamerato et al., however, cannot, we believe, reasonably defend the metastasizing CDC schedule in Figure 2 with its accompanying 14 additional pages. Apparently, it is only the marketeers and controlling technocrats along with compliant medical professionals who continue to deny the disaster of the bloated CDC "childhood" vaccine schedule, along with the disaster of 13+ billion doses of COVID-19 "vaccines" (Pharmaceutical Technology, 2024) that were distributed worldwide. Of the COVID-19 injectables, 676,728,782 doses were administered in the US to about 230 million recipients (USAFacts, 2025). As that was taking place, the independent research was showing all along the way that every additional dose was doing more harm than the previous one (Kirsch, 2023; Oller & Santiago, 2025).

The experimental COVID-19 injectable gene therapies that were misrepresented and promoted as "safe and effective" and as "vaccines", constitute by far the largest and most damaging "medical" experiment ever undertaken in the recorded history of the world. However, together with the Henry Ford Health System study under review here — as Hulscher has recently noted (2025c) — we must also point to another damning study showing vaccine harm that was recently published in

BioMedCentral Infectious Diseases by Cinta de Diego Cabanes, et al. (2025). Within a 95% confidence interval for multiple measures examining 2.3 million recipients adjusted for effects of age, sex, flu shots received, and comorbidities, she and her colleagues found that the much advertised pneumococcal vaccine PCV13 increased by 83% the likelihood that recipients would contract one of the particular pneumonias that shot was supposed to prevent, and increased by 55% the likelihood that recipients would contract at least some variety of pneumonia, and for those who received the vaccine and happened to get pneumonia, they were 91% more likely to die of pneumonia. Although the PCV13 was pulled from the market, PCV15, PCV20, and PCV21 remain and differ from PCV13 only in the number of pneumococcal variants — 13, 15, 20, and 21 — they contain. Another pneumococcal vaccine, PPSV23, increased the risk of pneumococcal infections by 21% and upped the incidence of pneumonia from all-causes by 24% with no reduction whatsoever in mortality.

Lamerato et al. (2020-2025) begin with the following observation:

> Over the past 30 years, the prevalence of chronic health conditions in children has increased (Van Cleave et al., 2010). According to a 2011 study, approximately 43% of children in the United States (32 million) have at least 1 of the 20 chronic health conditions assessed in the study (Bethell et al., 2011). Despite this, there is a paucity of published data to determine contributing factors.

It is interesting that the focus of both the articles cited at the top of the Lamerato et al. study seems to be on the capacity of the increasingly injured people to pay for medical services. The words "cause" and "causation" do not appear even once in either of the cited papers complaining about the ongoing increase in chronic diseases in children. Is it not curious that Van Cleave et al. as well as Bethell et al. seem to be more concerned about whether or not the injured parties have insurance coverage, enabling them to pay for services, than they are with whatever may be causing the increase in chronic diseases? Could the "paucity of published data" about causation of chronic disease conditions be owed to the determination of mainstream epidemiologists to studiously avoid any mention of "causes" or "causation"? Could it be that they realize questions about causation are certain to lead to the toxicants in vaccines and from there to the whole CDC vaccine schedule?

In their very next sentence, Lamerato et al. seem to anticipate the likelihood that intelligent persons taking account of the exponential growth in chronic disorders appearing in younger and younger children will think of the CDC's self-sustaining vaccine schedule as the most likely culprit. Vaccines, as is well-known, are far-and-away the biggest money-makers for the $7.03 trillion dollar (Tohi, 2025; Wikipedia, 2025) industry of medical practitioners, pharmacies, hospitals, and medical schools in the world. Lamerato et al. (2020-2025) persist in tacitly, it seems, what Siri calls the "religion of vaccines":

> Vaccination has reduced the incidence of certain targeted childhood infections and their associated morbidity and mortality (Hinman et al., 2011). [The foregoing statement is false according to the findings of Lamerato et al.] Nonetheless, vaccine hesitancy remains a significant barrier to maintaining and increasing vaccine uptake [implying falsely that the uptake of vaccines is intrinsically desirable because "vaccines are good"] and the number of parents foregoing all vaccinations [implying that the parents are making a bad decision] has been increasing (Schuster et al., 2015; Hill et al., 2018). Common parental concerns relate to the growth of the vaccine schedule, administering multiple vaccines contemporaneously, and the potential for long-term adverse health outcomes from vaccination (Gellin et al., 2000; Chen et al., 2001; Kennedy et al., 2011; Saada et al., 2015). Research addressing these vaccine safety concerns [here the authors understate the reasonable fear that the vaccines are actually causing disease and death] can assist clinicians in discussions with their patients and serve to reassure parents of

> the overall safety of vaccination (Institute of Medicine et al., 2013) [again, the authors present what appears to be a falsehood as if it were true; and perhaps they believe it in spite of the results of their own study].

It stands to reason, in light of independent research (Garner, 2022; Hulscher et al., 2025), that parents do not blithely reject the CDC mandates concerning vaccines. They do so, as documented by Siri (2025, p. 262ff) against opposition, penalties, threats, social stigmatization, and ostracism by some of the compliant individuals and the medical establishment funded by the same sources as the CDC and its benefactors — chiefly the massive pharmaceutical industry and the captured government agencies that sustain it. Apart from paid pharmaceutical lobbyists, the mainstream medical publishers, doctors, many professors in medical schools, and so forth, are indoctrinated and are also incentivized to go along with the mainstream marketing propaganda (Angell, 2009; Liu et al., 2017; Wong et al., 2017; Dal-Re et al., 2019; Niforatos et al., 2020; Harlianto & Harlianto, 2024; Rizer et al., 2025). The compliant majority are rewarded by the wealthy medical-pharmaceutical-industrial stakeholders, and those who fail to fall in line with the corporate narrative are coerced by the captured government agencies by the withholding of funds and the like.

However, the truly independent research concerning vaccines in general shows that many of these products are harmful and worse than useless as disease prophylactics (Miller & Blaylock, 2017; Miller & Goldman, 2023; de Diego Cabanes et al. 2025). The universal biosemiotic difficulty that vaccinology encounters is that the body's natural immune defenses do not benefit from being deceived by the unnatural ingredients of the injections manufactured to imitate, to some degree, either a natural infection or an assault by a hoard of toxicants (Oller, 2010, 2014, 2022).

Lamerato et al. note:

> The safety review period in pre-licensure clinical trials is typically of insufficient duration (<30 days) to assess a vaccine's impact on long-term health outcomes (Chen, 1999). However, a number of post-licensure observational studies have, with mixed results ["mixed" only if advertising is equated with research], examined whether certain vaccines are associated with developing certain health conditions (Nilsson et al., 1998; Hurwitz & Morgenstern, 2000; DeStefano et al., 2002; McDonald et al., 2008; DeStefano et al., 2013). An important limitation to these studies, as highlighted by the Institute of Medicine (IOM) report, The Childhood Immunization Schedule and Safety (2013), is that "most vaccine-related research focuses on the outcomes of single immunizations or combinations of vaccines administered at a single visit", instead of comparing completely unvaccinated populations with those receiving one or more vaccines. This led the IOM to recommend retrospective studies evaluating the health outcomes of vaccinated versus unvaccinated populations.

Given what the pharmaceutical industry would stand to lose, it is hardly surprising that no such studies were ever fairly conducted up to the time of this project by Lamerato et al. which began in 2020 and is still under close scrutiny in 2025. In our judgment, the IOM should have recommended a systematic comparison of patients who never received a single dose of the vaccines on the CDC schedule, versus those who received just 1 dose, versus 2 doses, etc., throughout the whole schedule up to the 81+ doses in the schedule.

It is already known what the outcome must be for any such comparison. Moreover, studies of the sort required have already been done for childhood vaccines (Hooker & Miller, 2020; Jablonowski & Hooker, 2022, 2024) as well as for the COVID-19 concoctions (Oller & Santiago, 2022; Kirsch, 2023; Santiago & Oller, 2023; Mead, Seneff, Wolfinger, et al., 2024; Mead, Seneff, Rose, et al., 2024; Hulscher et al., 2024; Szebeni & Koller, 2025; Speicher et al., 2025; Oller & Santiago, 2025; Hulscher et al., 2025) and the pneumococcal adult vaccines (de Diego-Cabanes et al., 2025). Lamerato et al.

suggest that their own study might help to fill in the gap — the paucity of mainstream research comparing vaccinated persons to ones who are completely unvaccinated which has been a near complete absence of any such studies:

> Hence, this study compared the short and long-term health outcomes, within a captured payer environment, of children unexposed to vaccines with those exposed to one or more vaccines. Addressing this significant data gap could allay parental concerns and bolster vaccine confidence [as if these objectives are naturally good ones, even if sustained only by advertising].

Whereas the authors admit statistically significant contrasts favoring the unvaccinated cohort for "asthma, atopic, autoimmune disease, and mental health and neurodevelopmental disorders including developmental delay and speech disorder" they assert that a

> statistically significant association was not found between vaccine exposure and the incidence of cancer, food allergy, autism, motor disability, or neurological, or seizure disorder.

The reason they give for not finding any relation in some instances is that a real quantity cannot be divided by zero. Whereas it may be impossible logically and algebraically to divide any real quantity into ever so many parts containing nothing at all, that fact does not make it impossible for us to compare a value of zero against a real quantity that is, theoretically, infinitely larger. In fact, using the nonparametric rank order of the disease conditions in the unvaccinated group (see columns 9 and 10 in Table 1) compared to those in the unvaccinated group by Welch's *t*-test for independent samples with unequal sample-sizes, variances, and non-normal distribution we find that the likelihood of a contrast as large as the one found by Lamerato et al. (2022) occurring by chance is $p < 0.02$. Given that this contrast has nothing to do with any carefully selected "genetically susceptible" population, nothing whatever in the current study suggests that some subset of children is uniquely being impacted in a negative way by vaccines in the CDC schedule. There is no reason to suppose that the children enrolled in the Henry Ford Health System that are developing chronic health conditions are different from those who do not develop such conditions. What the study shows is that being exposed to vaccines greatly increases the likelihood of developing such conditions in ordinary children with no special genetic conditions being required.

Lamerato et al. also make mention multiple times of biological "mechanisms" — five times, for instance, on pages 10 and 11 as if the ordinary processes of maintenance, repairs, and defenses of the human body were purely mechanical processes. This manner of thought is misleading. The biosignaling systems upon which our health and well-being depend are not mechanistic any more than ordinary processes of communication between intelligent beings are mechanistic. They are, on the contrary, dependent on interactions between dynamic systems of systems of great intricacy and complexity that must logically be at least as complex as those manifested in our unique human language capacity (Chomsky, 2011; Berwick & Chomsky, 2017; Oller & Shaw, 2019; Oller, 2022b). If that capacity which is somehow enabled by our unique genetic make-up is not strictly mechanical, why should the vaccine manufacturers suppose that the communications taking place between our genome, proteome, our microbiome, our organ systems, or any aspects of our biosignaling systems are strictly mechanical? The nature of successful communications in general defies any such reductionistic claims. The authors, Lamerato et al., it seems try to sidestep the problem:

> elucidating how vaccine exposure in certain individuals might increase a health risk are unclear and beyond the scope of this study, but likely differ by condition, vaccine and recipient characteristics. A common theme in the literature is that vaccination may trigger a genetic and/or immunologic susceptibility (Sibilia & Maillefert, 2002; Vadalà et al., 2017).

We reject the notion that only a minority of people are "susceptible" to being injured by the toxicants in the vaccines mandated by the CDC. Such a claim cannot be defended sensibly any more than the notion that only some people, a minority of the world's population, can be expected to be susceptible to injury by falling from a height onto a hard surface, or that only a minority of people are susceptible of injury from bullets, radiation burns, and toxicants in general. Whereas some people are more capable of recovering from all such injuries, that does not justify theclaim that those who recover better than others are not also harmed by the injuries from which they may be able to recover. It must be supposed that the toxicants, disease agents, etc., in the CDC vaccine schedule are universally harmful to ordinary human beings. Vaccinology appears to be the only domain in medicine where it is argued, oddly enough, that exposure to disease causing agents laced with injurious toxicants or modified nucleic acids will improve the health of recipients. As regards the consistent corporate claim that these products are necessarily safe, we are reminded of Bill Gates' admission in Brussels about the lack of safety testing:

> Is there something to worry about with medicines; that is, might some of them have side-effects? Do we need safety testing? We're taking things that are genetically modified organisms, and we're injecting them into little kids' arms. We just shoot 'em right into the vein. So, yeah I think maybe we should have a safety system, where we do trials, and test things out (Gates, 2021).

Some Interesting Ideas about Epigenetics

Near the middle of their defense of vaccines, Lamerato et al. suggest that "epigenetic" factors may be causing certain individuals to be susceptible to vaccine injuries. Their argument is something like saying that the internal organs, say, the heart, lungs, brain and other body parts damaged by shotgun pellets, or by heavy atomic particles, just happen to be susceptible, because of their biochemistry, to whatever injuries are sustained. Their argument seems to suggest that the epigentic systems in persons who are injured by vaccines just happen to be such as to cause their injuries. This is the sort of logic that seems to be applied in the following text:

> Epigenetics is an emerging field of study which explores how the environment can influence how genes are expressed without involving alterations in the DNA gene sequence. Research has shown that epigenetics may play a role in the pathogenesis of many diseases, including asthma, atopy, eczema, autoimmune disease, and neurodevelopmental disorders, though precise etiologies vary and remain largely unknown (Bollati & Baccarelli, 2010; Kuriakose & Miller, 2010; Costenbader et al., 2012; Millan, 2013; Gomez, 2019; Mervis & McGee, 2020). Genetically-mediated individual variations in the immunogenicity and reactivity of vaccines has been demonstrated (Poland et al., 2008, 2009). The field of vaccine "adversomics", though in its infancy, seeks to bring a precision medicine approach into vaccine practice by utilizing advanced genomic, epigenetic and biostatistical approaches to better identify individuals susceptible to an adverse vaccine outcome to prevent or minimize adverse consequences (Poland et al., 2009; Whitaker et al., 2015).This is important because, as the CDC emphasizes, vaccines are generally given to healthy persons preventatively, and because of their widespread use, any safety issue, even if rare, can impact large numbers of people (Centers for Disease Control and Prevention, 2019). The results of this study, while preliminary, suggest that we currently underestimate the group susceptible to an adverse vaccine effect [as if that particular subpopulation must be peculiar in some unknown way].

The very idea that these products, without any long-term testing, can nonetheless be injected into human beings violates the time-honored principle — at least from Hippocrates forward — that doctors should do no harm. Yet, given that vaccination aims to stir the body's immune defenses with the false threat of invasion by disease, the idea that only a minority of the population will turn up

being "susceptible" to injury by a multitude of such assaults is like supposing that only some trainees working with live-fire in a military context are being exposed to possible injuries or death. Lamerato et al. write:

> Vaccines aim to stimulate an antigen-specific immune response, however there are significant gaps in understanding the complex immunological mechanisms involved, and concern has been raised about potential untoward or off-target immunological effects in susceptible recipients (Pulendran & Ahmed, 2011; Kandasamy et al., 2016). According to an IOM report, epidemiologic and mechanistic research suggest that most individuals who experience an adverse response to a vaccine have a preexisting susceptibility due to genetic variants (in human or microbiome DNA), environmental exposures, behaviors, intervening illness, developmental stage or others (Institute of Medicine & Committee to Review Adverse Effects of Vaccines, 2011). Viewed as an environmental exposure, in addition to antigens, vaccines also contain small amounts of preservatives, adjuvants, additives and residual substances from the manufacturing process (Offit et al., 2002;[4] Offit & Jew, 2003). While this study cannot delineate the impact of epigenetics or a particular vaccine component, the unexposed group was not exposed to vaccine components, and the exposed group to one or more.

In fact, the underestimation hits the highest possible upper limit because every person in the population receiving the vaccines is known in advance to be subject to injuries by the toxicants, disease agents, interactions, etc. contained in the vaccines. Lamerato et al. seem almost to acknowlege all this when they write:

> We found a 6-fold increased risk of autoimmune disease in the group exposed to vaccine(s). Certain vaccines, or adjuvants, have been implicated in autoimmune conditions such as thrombocytopenic purpura, rheumatoid arthritis, systemic lupus erythematosus, multiple sclerosis and Guillain-Barré syndrome (Shoenfeld & Aron-Maor, 2000; Chen, Pless, et al., 2001; Karussis & Petrou, 2014; Centers for Disease Control and Prevention, 2019). . . . We found an over 4-fold increased risk of asthma and over 6-fold risk of asthma attack in those exposed to vaccination.

There is no legitimate doubt that many, if not all, of the body's normal biosemiotic systems on which our health depends are being assaulted by the toxicants and other ingredients in the vaccines, but the notion that the biosignaling systems that are being injured are somehow responsible for or causing themselves to be damaged, is implausible. Consider a simple analogy: does it make sense to suppose that the internal organs of a victim injured by a shotgun blast, or exposure to intense nuclear radiation, have been harmed in some way by special conditions that made that particular person's heart or brain susceptible to injury by shotgun pellets, or by heavy atomic particles? Here is some of the reasoning supporting such a view:

> Epigenetics is an emerging field of study which explores how the environment can influence how genes are expressed without involving alterations in the DNA gene sequence. Research has shown that epigenetics may play a role in the pathogenesis of many diseases, including asthma, atopy, eczema, autoimmune disease, and neurodevelopmental disorders, though precise etiologies vary and remain largely unknown (Bollati & Baccarelli, 2010; Kuriakose & Miller, 2010; Costenbader et al., 2012; Millan, 2013; Gomez, 2019; Mervis & McGee, 2020). Genetically-mediated individual variations in the immunogenicity and reactivity of vaccines has been demonstrated (Poland et al., 2008, 2009). The field of vaccine "adversomics", though in its infancy, seeks to bring a precision medicine approach into vaccine practice [is anything precise

[4] This was the paper in which Offit claimed a baby could handle 10,000 vaccines simultaneously before using 1/100th of the available B-cells.

> about vaccine practice?] by utilizing advanced genomic, epigenetic and biostatistical approaches to better identify individuals susceptible to an adverse vaccine outcome to prevent or minimize adverse consequences (Poland et al., 2009; Whitaker et al., 2015).This is important because, as the CDC emphasizes, vaccines are generally given to healthy persons preventatively, and because of their widespread use, any safety issue, even if rare, can impact large numbers of people (Centers for Disease Control and Prevention, 2019). The results of this study, while preliminary, suggest that we currently underestimate the group susceptible to an adverse vaccine effect [as if that particular subpopulation must be peculiar in some unknown way].

The Role of Toxicants in Vaccines

The authors explicitly acknowledge toxicants in the vaccines but try to minimize any evidence that they are harmful:

> . . . a recent study . . . found that out of 34 ingredients, only aluminum exposure could be consistently quantified, but did not subsequently evaluate aluminum's impact on clinically meaningful outcomes (Glanz et al., 2015).

Careful research shows that the impact of aluminum compounds in vaccines is neither negligible nor harmless (C. A. Shaw & Petrik, 2009; Burrell & Exley, 2010; Tomljenovic, 2011; Tomljenovic & C. A. Shaw, 2011a, 2011b; Seneff et al., 2012; Tomljenovic & C. A. Shaw, 2012; C. A. Shaw et al., 2014; C. A. Shaw, Seneff, et al., 2014; Dórea, 2015; Seneff et al., 2015; Exley, 2017; Inbar et al., 2017; Lyons-Weiler & Ricketson, 2018; Gherardi et al., 2019; Crepeaux et al., 2020).

Where Lamerato et al. found clear evidence that the vaccines are doing harm they seem to cover it with a blanket of vagueness:

> We found a strong association between vaccine exposure (versus no exposure) and development of a neurodevelopmental disorder (HR 5.84, CI 3.02-11.27) even after controlling for gender, race, birth-weight prematurity, and other factors. This increased risk was primarily driven by speech disorders, developmental delays, tics, ADHD, and behavioral, and motor disabilities. The etiology of this association is unclear, but it suggests that vaccination may serve as an environmental influence in susceptible children.

Unclear? No, and it is incorrect from a purely logical perspective to regard "speech disorders, developmental delays, tics, ADHD, and behavioral, and motor disabilities" as causes of the chronic conditions they merely name or describe. Vaccine injuries are not "driven by" symptoms any more than gunshot wounds are caused by trauma, bleeding, organ failure, and sometimes death. The reverse is true.

The Strengths of Their Own Work

Lamerato et al. suggest some "Strengths" of their own work:

> Though some results were unexpected, others are consistent with conclusions from prior systematic reviews, including by the IOM, such as the accepted causal relationship between vaccination and anaphylaxis, which we observed, or the rejection [actually, IOM did not reject the possibility, that body of reviewers merely said there was no good evidence] of a causal relationship between vaccination and cancer or MMR vaccine and autism (Institute of Medicine & Committee to Review Adverse Effects of Vaccines, 2011; Maglione et al., 2014). This contributes to the internal validity of this study's findings.

However, their claim regarding vaccines and cancer does not hold up under careful scrutiny. Their own results on row 6 of Table 1, with 169/19,511 cases of cancer in the vaccinated cohort contrasted with 13/1,957 cases in the unvaccinated shows a proportional contrast favoring the unvaccinated by 54% and yet the contrast per 1,000,000 patient-years in columns 3 and 4 oddly seems to favor vaccinated patients. Perhaps the patient-year numbers on that row are mistaken. Regardless, there can be little doubt that vaccines and their components, e.g., the Simian 40 virus in the polio vaccines (Stenton, 1997; Hilleman, 1998) and the polysorbate 80 (Coors et al., 2005) in many other vaccines, not to mention the COVID-19 concoctions now recommended by the CDC for inclusion in the childhood schedule (Hulscher, 2025a; Chandler, 2025; Hulscher, 2025b; Kuperwasser, 2025) are contributing to an increased incidence of cancers especially in children (Soon-Shiong, 2025). It must be noted here that cancers in children and adolescents were extremely rare until the advent of the COVID-19 vaccines which brought with them a host of new disease conditions including the most rapidly developing cancers ever seen (Mead, Seneff, Wolfinger, et al., 2024; Mead, Seneff, Rose, et al., 2024; Marik & Hope, 2025; Hulscher, 2025a).

Nor can a single study, much less one that reported a proportional contrast of 2.721 favoring the unvaccinated cohort over the vaccinated for the diagnosis of autism be used to claim proof that there is no relation between the MMR measles virus and the causation of the neurodevelopmental conditions seen in the autism diagnosis. If anything, the Lamerato et al. results show that the CDC vaccine schedule is causally implicated with respect to many of the symptomatic conditions associated with the autism spectrum. In fact, if we calculate the proportion of common symptoms in the vaccinated cohort on rows 10 through 19 of Table 2 to contrast with the proportion seen in the unvaccinated cohort, the outcome favors the unvaccinated children by a multiplier of 12.507. To claim that the results of Lamerato et al. vindicate the false hope that the vaccines on the CDC schedule are not causally implicated with respect to autism is unfounded.

Legal Action Challenging the CDC Schedule

The Lamerato et al. findings take on even greater significance in light of recent legal action targeting the CDC's vaccination policies. In August 2025, a federal lawsuit filed by Paul Thomas, MD, Kenneth P. Stoller, MD, and Stand for Health Freedom, accused the CDC of operating an illegal and unconstitutional 72-dose childhood vaccine program — one that has never undergone cumulative safety testing despite repeated warnings from the Institute of Medicine (2002, 2013). The complaint (Thomas & Stoller v. Monarez & the CDC, 2025) alleges that the CDC and HHS violated statutory duties under the National Childhood Vaccine Injury Act of 1986 by failing, since 1998, to submit biennial vaccine-safety reports to Congress while simultaneously enforcing a *de facto* national mandate through coercive policies and professional retaliation against dissenting physicians. The plaintiffs seek to reclassify all childhood vaccines under Category B (shared decision-making), to require rigorous vaccinated-versus-unvaccinated safety trials, and to end state and institutional retaliation against doctors who issue individualized exemptions. If successful, the suit would represent the first major judicial challenge to the CDC's untested "hyper-vaccination" schedule and could open the door to long-overdue regulatory accountability.

Together, the empirical findings from Lamerato et al. and the emerging legal challenges to the CDC's vaccination policies underscore the same central truth: *the existing childhood immunization program has never been subjected to comprehensive cumulative safety evaluation*. It is worth reminding readers that after many decades of claiming that vaccines are necessarily safe and the most studied products on earth that Stanly Plotkin and colleagues appeared to reverse their position in "Funding Postauthorization Vaccine-Safety Science," where they admit that "prelicensure clinical trials have limited sample sizes

[and] follow-up durations" and that "there are not resources earmarked for postauthorization safety studies" (Salmon et al., 2024). The Henry Ford cohort data now provide precisely the kind of population-level evidence that the CDC was legally obligated to produce. As the courts begin to examine whether federal agencies have breached both statutory and constitutional duties, the scientific record itself is converging on the same conclusion: the CDC's childhood vaccination schedule has unleashed a still growing chronic disease epidemic.

Conclusions

The Lamerato et al. study of a total population of 18,468 individuals between birth and 18 years of age during the years from 2000 to 2016 — of which the 16,511 in the vaccinated cohort received a median of 18 vaccines whereas the 1,957 in the unvaccinated cohort received none at all — probably represents the most comprehensive real-world comparison of vaccinated versus unvaccinated children ever conducted within a self-contained whole population in a full-service integrated health system in the US. The proportionate contrasts overwhelmingly favor the unvaccinated cohort. Every single one of the 22 chronic disease categories assessed had a higher proportion of the vaccinated cohort than the unvaccinated. Given the size of the cohorts which can be regarded as samples of the whole vaccinated and unvaccinated persons in the US, based on the central limit theorem, they must be regarded as probably representative of vaccinated and unvaccinated children across the board throughout the country. Can a retrospective study such as this one show incontrovertible causal relationships? Of course it can. Does this present study stack the deck in favor of the unvaccinated cohort? Is it in some way biased by unrevealed socioeconomic factors, or undiscovered dietary differences, or by an ascertainment bias that would falsely make the vaccinated cohort look sicker than the unvaccinated?

Our assessment is that none of those possibilities is plausible in view of the larger perspective of the independent research projects we have cited in our review of Lamerato et al. Independent research already on hand, e.g., Garner (2022), Mead, Seneff, Wolfinger, et al. (2024), Mead, Seneff, Rose, et al. (2024), Marik and Hope (2025), Hulscher (2025a), Chandler (2025), Hulscher (2025b), and Kuperwasser (2025) confirms the findings of Lamerato et al. showing incontrovertibly that more exposures to vaccines ensures more disease conditions. The CDC's childhood vaccine schedule is an unmitigated disaster in progress. In the neurodevelopmental cluster of chronic disease conditions — ADHD, developmental delay, speech disorder, tics, behavioural disability, etc. — there was a five to twelve times greater proportional incidence in the vaccinated cohort. According to the statistics reported by Lamerato et al. themselves, only 43 % of vaccinated children remained free of chronic illness at 10 years, compared with 83 % of the unvaccinated — meaning 57% versus 17% had developed at least one chronic health condition. Altogether, the results point to a unified pattern of immune, neurological, and metabolic injury consistent across multiple data sources. Our reanalysis further shows that the conditions which collectively form the clinical profile associated with autism spectrum disorder — including autism itself, ADHD, developmental delay, speech disorder, learning disability, and related neurological diagnoses — occurred at 5.49-fold (549%) higher odds in the vaccinated cohort. Their near-absence in the unvaccinated group represents perhaps the clearest population-level experimental demonstration to date that vaccines are causing the still rising epidemic of chronic disease conditions. We appreciate that Zervos, and his colleagues accepted the challenge by Del Bigtree (2025a) and caused the Lamerato et al. study to be done. Although the results, we believe, are subject to the concerns we have expressed, they add measurably to the emerging dialogue about the injurious impact of the CDC vaccine schedule that are beginning to be recognized by a growing segment of the public.

Acknowledgments

We are grateful to the various members of Editorial Board for the *IJVTPR* who in addition to ourselves also reviewed the work by Lamerato et al. (2020-2025). Those who reviewed Lamerato et al. included, in addition to ourselves as authors of this paper, Robert M. Davidson, MD, PhD; Mary Holland, Esq.; Brian Hooker, PhD; Christof Plothe, OD; Asgeir Saebo, MS; Daniel Santiago, PharmD; Stephanie Seneff, PhD; Christopher A. Shaw, PhD; Mark Skidmore, PhD; and Shimon Yanowitz, EE. For the review of the present paper, Christopher A. Shaw temporarily replaced Oller as Editor-in-Chief and obtained reviews by Stephanie Seneff and Daniel Santiago. Those reviews, we believe, have led to significant improvements. Any errors or infelicities remaining are ours alone.

Conflicts of Interest

The authors have no conflicts of interest to declare.

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[5] Although this study was scrubbed from the CDC website where it was originally posted, it can be found at the link provided by independent researchers. It was notorious for having been posted and later amended to suit the interests of the captured federal agency aiming to deny all possible evidences of any association between vaccine ingredients and autism. All hope for those denials has now evaporated entirely as independent researchers have begun to examine the CDC vaccine program as a whole, and especially those shots "recommended" to the pediatricians and parents of children between birth and age 18. The untampered with independent research is 100% against the CDC mantras of "safe and effective", that vaccines "have saved millions of lives every year", and so forth. Those claims about the "settled science" in favor of vaccines is marketeering and it is false.

[6] In this 2003 paper, the authors from 1999 perjured themselves and falsified outcomes by sleight-of-hand with statistical jargon and cherry-picked analyses (Gale & Null, 2017).

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