



Warren Heymann

Director, American Board of Dermatology (ABD)

“We have individual studies on what works and what doesn't work, but we need more comparative studies”

Disclaimer:

These answers are Heymann's personal opinions only and do not represent the views of the American Board of Dermatology (ABD).

Citation:

Dermatol AMJ. 2026;3[1]:81-85.
<https://doi.org/10.33590/dermatolamj/707QV0W0>

Q1 What initially inspired you to pursue dermatology, and how did your early experience help shape the way you approach patient care today?

When I was in medical school, my brother had a rash. In retrospect, it was probably pityriasis rosea, but I don't know that for a fact. At the time he showed it to me, I was a second-year student, and I really had no idea what it was. He went running to my father and told him that he was throwing money out on me in medical school, so I thought maybe it would be a good idea to take a dermatology elective.

I was leaning toward internal medicine and that is what I originally applied to. One of my internal medicine residents, who I admired a lot, went into dermatology, so I decided the month before the Match that it was time to take on the elective. I was a fourth-year student, and within a few days I realized that dermatology was fun and interesting, and it clicked.

It was the first time I really felt that I could excel at something in medical school. Not just do okay, but do really well; it was just a gut feeling. But it was a very different world back then, in 1979, because it was not that competitive; there was no Match in dermatology. I was able to apply and, a couple of weeks later, had a spot where I went to medical school.

I was very impressed with our Chief of Dermatology at the time, Michael Fisher, especially about a case on the wards, which may have convinced me. This young man who had Crohn's disease, just like my brother, had a blistering rash that no one could figure out. Fisher just looked at the patient's hand and said: "He's deficient in zinc from his total parenteral nutrition. Supplement zinc." That person had acrodermatitis enteropathica, and this mysterious rash went away very quickly with the zinc supplementation. To me, that was magical.

Q2 Your publication record spans over 300 articles. Looking across the entirety of your work, where do you believe that the most significant gaps in dermatology currently lie, and what would you like to see more research on?

It's always an evolving issue. We're in the biologic era of targeted medicine, and these medicines are very expensive. We have individual studies on what works and what doesn't work, but we need more comparative studies, and we need to understand molecularly what the right medication is for the right person. So, there's a lot more research needed. Even though treatment is targeted, we need comparative studies that make it truly personalized with what's best for the individual. And we're not there yet.

We have an increasing number of biologics for a variety of indications and a variety of diseases, like psoriasis and atopic dermatitis, and increasingly alopecia and dermatomyositis. But with all these new offerings, right now, decisions are made based on insurance, and what an insurance company will pay for, rather than really understanding what the right biologic for the condition is.

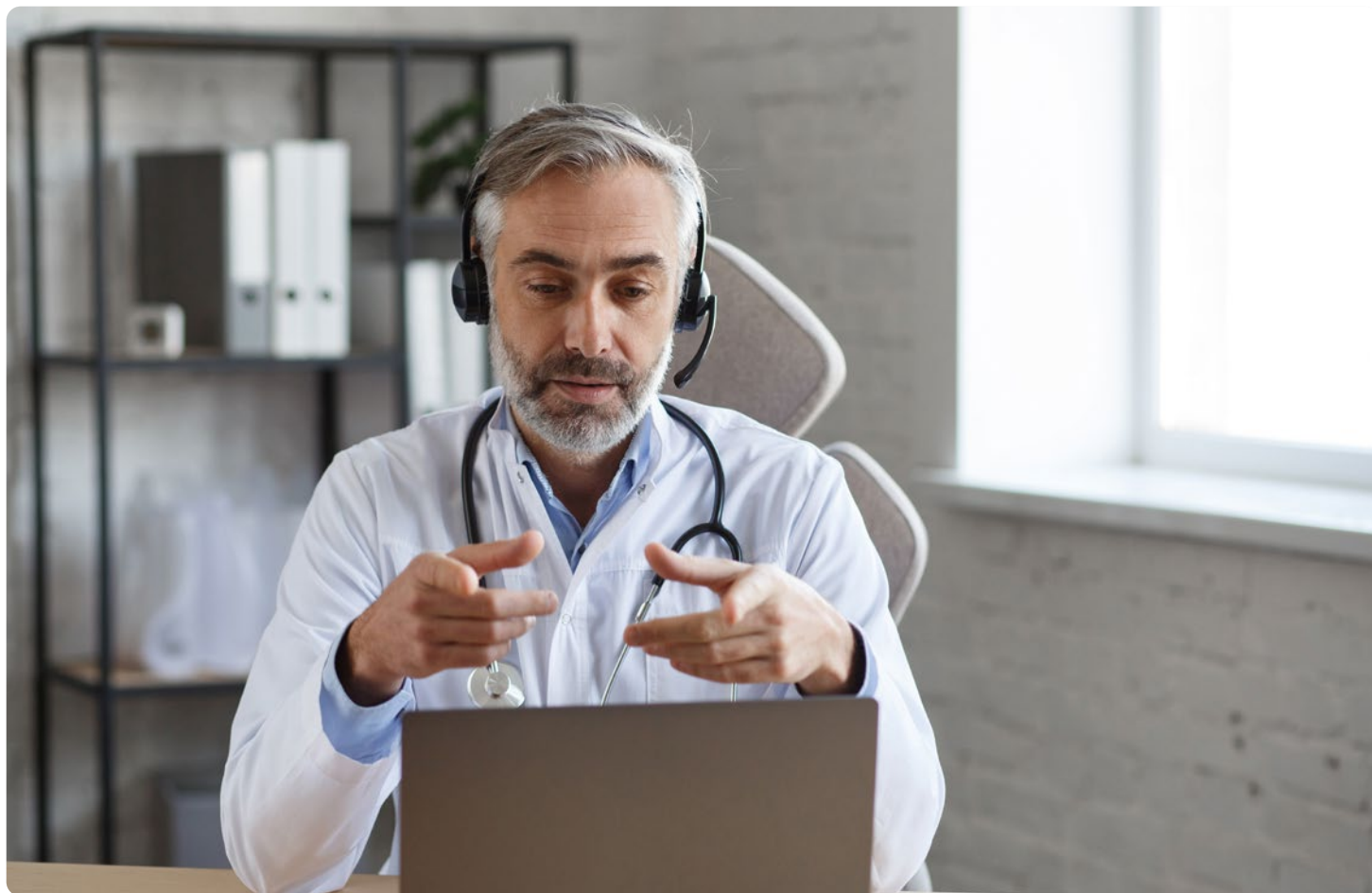
Q3 Over the past decade, dermatology has seen rapid developments in areas such as teledermatology, targeted immunomodulatory therapies, and new models of care delivery. From your clinical perspective, which of these advances have most significantly improved patients' quality of life, and are there any unintended consequences?

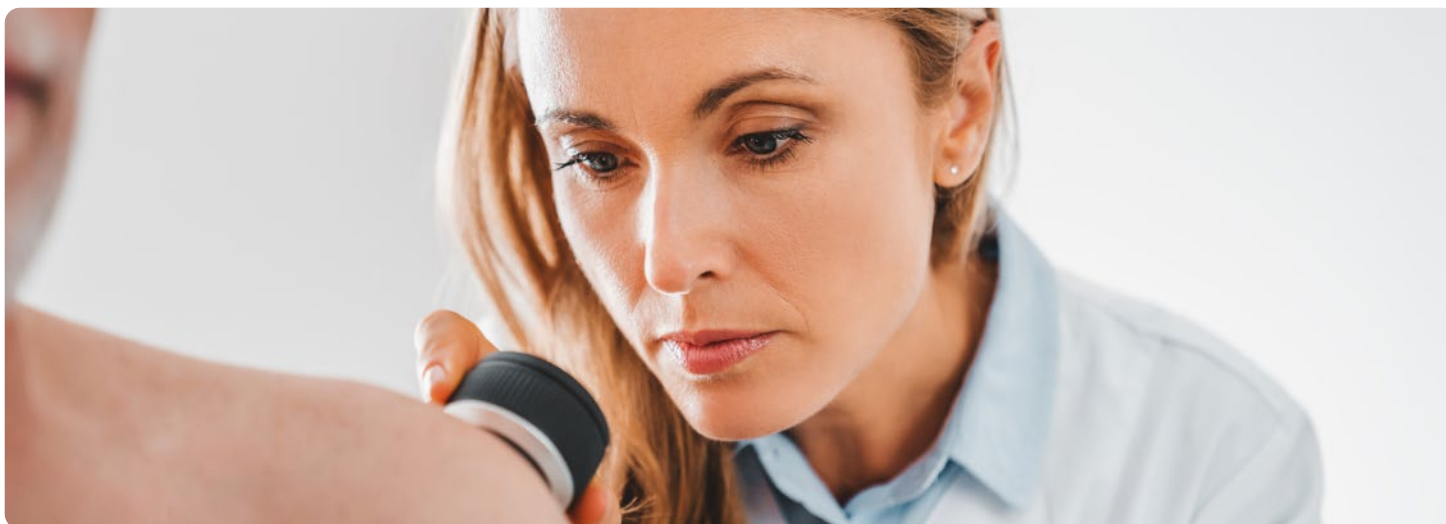
Teledermatology was being used a little bit in the past, and then COVID-19 came along, and it became a dramatic lifesaver, in a way. I think the use has backed off now in dermatology because of reimbursement and time. When we couldn't do anything else, it was incredibly valuable. But it doesn't compare to a real visit. You can't

hold a hand, you can't do a biopsy, you can't do a culture.

It still has its value if people are really underserved and can't be seen, but not to the degree that you could have in person. For example, if you are a college kid on isotretinoin, and you can't make it to the office, it's valuable, but while it will always be there, it is not optimal.

While I can't think of an unintended consequence, it has its limitations. Maybe there is a false sense of security. You can't do a full-body skin exam, and you can look at something that a patient is concerned about, but you didn't get their shirt off and see the melanoma on their back, because they weren't worried about it.





From the targeted immunomodulatory therapies, there are some unintended consequences as you use these. The one that comes to mind first when we were first using biologics such as tumor necrosis factor-alpha inhibitors like adalimumab was the development of paradoxical psoriasis. You gave it for psoriasis, and then it would get worse. I don't view it as paradoxical. I think it's an adverse reaction.

It can also happen with IL-17 inhibitors, like secukinumab. But we weren't aware of that. Dupilumab, for example, is still controversial. Are we unmasking cutaneous T cell lymphoma, or was it there from the start? That's a little bit of a debate. As you use new medications, sometimes you discover things you just didn't anticipate, and we can learn from those unintended consequences.

Q4 From your vantage point as a clinician and prolific medical writer, how would you use AI to accelerate dermatology R&D responsibly, and what safeguards do you think are non-negotiable for any healthcare field that wants speed without sacrificing truth?

AI is not limited to dermatology. It's in every aspect of our lives, right? And, like any tool, it could be used wonderfully or in a dastardly way.

Within the last year, AI has changed my approach to how I look at literature. When I was a dermatology resident, if I had to look something up, I'd have to spend a Sunday afternoon at the library, look at Index Medicus, pull books off the shelves, find articles, and photocopy them. It would take all afternoon to get three articles. Then we computerized, and PubMed came along, and now it would take you a few minutes. But now, with AI, you can ask any question, which is marvelous.

Now, the trouble is: do you stop there? I think you need real fundamental knowledge of your field to ask appropriate

questions and to have a deep enough knowledge to know when you're being duped, and when it's hallucinating or making things up.

So, you can't just stop there. If it includes the reference, you need to go to the original sources of the references to form your own opinion. But I think in clinic, when you're working quickly, and somebody asks a question that is something you hadn't thought about before, it can be marvelous. If used properly, to our advantage, and if you have healthy skepticism and don't take things at face value, it's remarkable.

Q5 As a mentor, having supported generations of trainees, in your experience, what distinguishes a competent dermatologist from an exceptional one?

That's an excellent question. The first reason has nothing to do with knowledge. It has to do with heart and compassion: being a person who really cares about their patients and their problems, and who is curious about finding the right answers and advocating for



their patient. In this day, anyone can get information instantly, so I think the most important thing is what is in a person's heart.

Anyone who goes through training and passes their boards is, by definition, good, but what makes them great is curiosity and recognizing potential problems when other people don't realize it. This can be paying attention to detail that uncovers illness that could easily get overlooked; recognizing a small lesion; not looking too quickly at the patient and, for example, recognizing arteriovenous malformations; and recognizing some large veins that could uncover thoracic outlet syndromes. It's about paying attention to detail and being curious.

Q6 Have you seen a shift in curiosity from previous generations of dermatologists versus current ones?

I wouldn't say it's a shift in curiosity. When I started, the

field was mostly general medical dermatology. For example, when I was a resident, there were only two Mohs surgeons in New York City, a city of 8 million people. Now, about 20% or so of all graduating dermatologists are surgeons. So, the sub-specialization has grown tremendously as the knowledge has grown. I think people are curious, and as knowledge expands exponentially, the field has become sub-specialized.

Q7 Throughout your career, you have been involved in teaching, research, clinical care, and leadership within dermatology. How have you seen the field evolve over the past several decades, and which innovations or shifts in thinking do you believe have had the greatest impact on the way dermatologists practice today?

Dermatologic surgery went from Mohs surgery to lasers, cosmetics, and plastic repairs, and it's magnificent. You have pediatric dermatology, advancements

in diagnosing and managing angiomas, and genetics, and the whole classification of ichthyosis is now changing based on the molecular defects of recognizing syndromes. So, whole exome sequencing and next-generation sequencing are redefining how we look at illness, based on a molecular level.

There have been huge advances in imaging in dermatology, targeted therapies, and biologics. I mean, 15 years ago, metastatic melanoma was essentially a death sentence, and now there are many cures. How fantastic is that?

When I started at my first job, I ran the psoriasis daycare center. It was tough work, and people would be grateful if you could get them to a Psoriasis Area and Severity Index (PASI) 40 with methotrexate and phototherapy and the like. Now, with the biologics, within a few shots, so many people have a PASI 100. They're completely clear, and they're upset if a spot comes back.

It's just mind-boggling to me how it has revolutionized. What used to be chronic, really hard conditions to control are now amazingly well controlled with biologics such as dupilumab and JAK inhibitors.

When I was in medical school, and I graduated medical school in 1979, we were learning about monoclonal antibodies and what they could theoretically do one day. And boy, is that day here. The advances have been incredible. Now we're moving into the oral IL-23 inhibitors, which are not even an injection anymore.

Q8 You were recently recognized with the 2025 Master Dermatologist Award. Reflecting on your career, what achievement are you most proud of, and what lessons from that experience would you share with the next generation of physicians entering dermatology and medicine more broadly?

I've been very fortunate in my career, and there are a lot of things I've done that I'm very proud of. But I guess the most important one was when I was getting started with my private practice and I was able to be involved with a new medical school at the time. That is now the Cooper Medical School of Rowan University, Camden, New Jersey, USA.

For 6 years I was alone, but my goal was to set up an academic division in private practice, with the goal of being in practice, but academically oriented, so that we could ultimately teach the next generation and learn to always be as current as could be.

After being head of that division for 35 years, I stepped down a few years ago. But we now have a respected academic division of dermatology, and that setup, with that goal, enabled me to be involved in other things that I'm certainly proud of, like writing *Dermatology World Insights and Inquiries*, and getting involved with the first six editions of this book called *Treatment of Skin Disease*.

We started the residency program a little over 30 years ago, and being able to watch it grow is the wellspring of everything, so I'm most proud of that. It's a wonderful experience to have trainees and watch them go on to have successful careers. Not everybody is going to go out and set up a residency program, but I would encourage anybody to set their sights high, to always keep learning, and to never be complacent.